

026870 DEC 12

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. N

86 33441

1. DECEASED NAME (TYPE OR PRINT) <b>KATHLEEN GAYE ADWEHL</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>10</b> YEAR <b>1986</b>			2b. HOUR <b>A.M.</b>						
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>21</b> YEAR <b>1944</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CALIFORNIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AWUE ARUNDEL</b> MD.						
10. CITY OR TOWN OF DEATH <b>EDGEWATER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS) <b>15 Willow Spring Dr</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a. STATE <b>MD</b>				13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>EDGEWATER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>15 Willow Spring Dr 21037</b>		
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>O.</b> LAST <b>TURNER</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MABEL</b> MIDDLE <b>A</b> LAST <b>RAWSON</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>553 66 2567</b>		17. INFORMANT <b>JONATHAN R. ADWEHL</b>			ADDRESS <b># 13</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**BREAST CANCER, METASTATIC**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-10</b> , 19 <b>86</b> , to <b>12-10</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12-10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Solen J. Jackson</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12-10-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Solen Jackson</b>				22e. ADDRESS <b>1837 Forest Dr Campole, Md 2101</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>12-10-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		23d. LOCATION CITY OR TOWN <b>SOUTHAND</b> COUNTY <b>P.G. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>TAYLOR FUNERAL CHAPEL</b> ADDRESS <b>ANNAPOIS, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 11 1986</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Jackson</b>	

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029460 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8633442

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST FAYE Johnston AISLEY			MONTH DAY YEAR 12 27 86			8:00 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female	White	MONTH DAY YEAR June 2, 1915	71 YRS			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Texas	USA			Anne Arundel MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis	845 Deerwood Court	Homemaker			Home			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MD	AA	Annapolis	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	845 Deerwood Court			2401	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						
FIRST MIDDLE LAST John Bernard	FIRST MIDDLE LAST Alice Faye Chestang	16b. SOCIAL SECURITY NO. 466-18-9142						
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
Harold Aisley		PART 1. DEATH WAS CAUSED BY:						
		IMMEDIATE CAUSE (a) <u>cardiac piratory Arrest</u>						
		DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic OAT CELL carcinoma of the lung</u>						
		DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
Jack R. Lichtenstein			MD			12/27/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Jack R. Lichtenstein			20 Ridgely Ave. Annapolis MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation			Dec. 3, 1986		Cedar Hill		Suitland PG MD	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Taylor Funeral Chapel-Annapolis, MD			JAN 5 1987			Julia T. ...		

10-2-1934

Dear Sir,  
I have the pleasure to acknowledge the receipt of your letter of the 2nd inst. in relation to the above matter.  
The same has been forwarded to the proper authorities for their consideration.  
I am, Sir, very respectfully,  
Yours faithfully,  
[Signature]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) <b>HERMANN</b>		FIRST MIDDLE LAST <b>Marin<sup>us</sup> ALLENDORF</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 24 1986</b>		2b. HOUR 7:51 AM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 5, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>63 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT LISTED ON FACE OF DEATH CERTIFICATE) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FORMED PART OF WORKING LIFE) <b>Ret. Firefighter/Balto.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Ferndale</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rudolph Allendorf</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Taybore</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		17. INFORMANT ADDRESS <b>Evelyn E. Allendorf Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic obstructive pulmonary disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic obstructive pulmonary disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6/6 86 12/24 86</b>			
22a. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>6/6 86</b> to <b>12/24 86</b> , that (I) <b>(was)</b> last saw the deceased alive on <b>11/20 86</b> , and that in (my) <b>(own)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(was not)</b> (did not) view the body after death.							
22b. SIGNATURE <b>Gerard Church M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/29/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GERARD CHURCH</b>				22e. ADDRESS <b>8 EVERGREEN ROAD SEVERNA PARK, MARYLAND 21146</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/29/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process Inc</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Balto., Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>McCully Funeral Homes Balto.Md. 21225</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 2 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MELVIN Henry Anderson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/9/86</b>			2b. HOUR <b>10</b> A M	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 8 93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Glenn Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Arundel Geriatric &amp; Nursing Center</b>		12a. USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>A.A.C.O. Bd. Ed</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Millersville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Anderson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Johnson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>218-10-1493A</b>	
17. INFORMANT ADDRESS <b>Baltimore md 21245</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio - pulmonary arrest</b>		19. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Car of epiglottis</b>		20. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ascar</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Ascar</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/2</b> , 19 <b>86</b> , to <b>12/9</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>12/2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Elmo M. Gayoso, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12/10/86</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELMO M. GAYOSO</b>		22f. ADDRESS <b>5411 Old Fredrick Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>12/13/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Taber</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chestertown AA Md</b>	
24. FUNERAL DIRECTOR <b>Wm Rees Sons</b>		ADDRESS <b>Annapolis, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John B. ...</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon pages 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 refers to any injury, or other traumatic event, the funeral director must notify the State Dept. of Health and Mental Hygiene.

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*



026408 DEC

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE A BALTUS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 01, 1986</b>			2b. HOUR <b>806 PM M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 15 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>99</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Electric</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Linthicum</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>303 Homewood Road 21090</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>===== Baltus</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Melchien</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>175-07-6371</b>		17. INFORMANT ADDRESS <b>Catherine A. Thierer Same as 13e</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1WK</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>11/25</b> , 19 <b>86</b> , to <b>12/1</b> , 19 <b>86</b> , that (we) last saw the deceased alive on <b>12/1</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lorraine M. Dailey MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/2/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LORRAINE M. DAILEY, M.D.</b>						22e. ADDRESS <b>8667 FT. SMALLWOOD RD. PASADENA, MARYLAND, 21122</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/6/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Erie Erie Co. Penna.</b>		
24. FUNERAL DIRECTOR <b>George J. Gonce</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1986</b>		25b. REGISTRAR'S SIGNATURE <b>J. Anderson-Randall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



027165 DEC 15 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM ELLSWORTH BARNETT JR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 09, 1986</b>			2b. HOUR <b>225 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 26, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Union</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7656 Altoona Beach Rd. 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William E. Barnett, Sr</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred I. Bates</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Florence E. Barnett (Same as 13a-e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Seven obstructive lung diseases</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic lung diseases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/9/86</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (i) this hospital attended the deceased from <b>11/9/86</b> to <b>12/9/86</b> , that (ii) we last saw the deceased alive on <b>12/8/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) did not view the body after death.										
22b. SIGNATURE <b>George B. Ramirez</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/9/86</b>		
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE B. RAMIREZ, M.D.</b>						22d. ADDRESS <b>7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 12, '86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Pk</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium Baltimore MD</b>		
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 12 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain portions of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EST

0371 17 12

WILLIAM ELLSWORTH BARNETT JR. DECEMBER 09, 1986 232 PM

WANE ARUNDEL COUNTY

CLIN BURNIE NORTH ARUNDEL HOSPITAL

①

10% FROM EPOCH

12/1/86

CLIN BURNIE, (ARUNDEL 21061)  
5845 GARDWOOD ROAD

JORGE B. RAMIREZ, M.D.

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marjorie Bartholf			2a. DATE OF DEATH MONTH DAY YEAR Dec 10, 1986			2b. HOUR 2:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 13, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Charles S. Bartholf		15. MOTHER'S MAIDEN NAME Grace C. Bohlock		13e. STREET ADDRESS / ZIP CODE 760 c Fairview Ave. 21403			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT BENTRICE B. HILTBIDLE #13		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>C.O.P.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 12/10/86 to 12/10/86, that (I) (we) last saw the deceased alive on 12/10/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Bentrice B. Hiltbidle MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Forest Dr. Annapolis MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12-11-86		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG. MD.	
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL		ADDRESS Annapolis MD.		25a. DATE REC'D. BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE John B. ...	

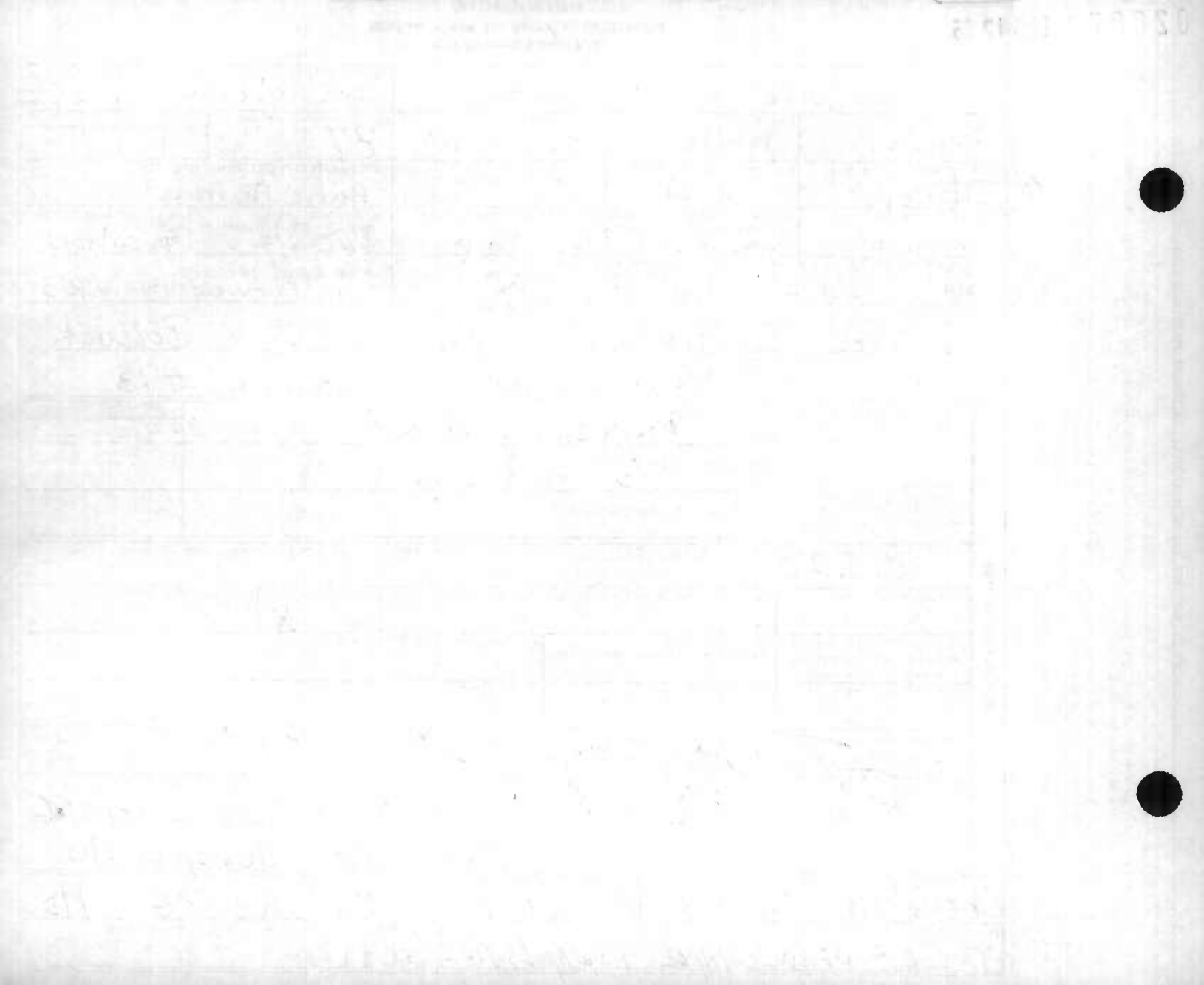
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's representative should be notified at once.

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George E. Baumann			2a. DATE OF DEATH MONTH DAY YEAR 12 28 86			2b. HOUR 1:30 AM			
3. SEX male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 02 27 1900		6. AGE (IN YEARS (LAST BIRTHDAY)) 86 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. md.		7b. CITIZEN OF WHAT COUNTRY? —		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH P. Camelsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH FACILITY, GIVE STREET ADDRESS) P. Camelsville North Laurel Co. Me.				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR OCCUPATION Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) P. Camelsville		13b. COUNTY P. Camelsville		13c. CITY OR TOWN P. Camelsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 385 Dutchship Rd. 31123	
14. FATHER'S NAME (FIRST MIDDLE LAST) Charles Baumann		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Kristine Bender		16. SOCIAL SECURITY NO. 214-14-7130A		17. INFORMANT City Fletcher		ADDRESS 385 Dutchship Rd. 31122	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. 214-14-7130A		18c. DATE OF DEATH 12/28/86		18d. CITY P. Camelsville		18e. STATE MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Dementia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Anemia, arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12 3 19 86 to 12 28 19 86, that (I) (we) last saw the deceased alive on 12 10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mustafa C. Oz		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12 28 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mustafa C. Oz		22e. ADDRESS 605 G-4 Blvd S.P.							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 12/31/86		23c. NAME OF CEMETERY OR CREMATORY Goodman Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE P. Camelsville MD 21116			
24. REGISTRAR Charles D. Stevens		ADDRESS 41501 E. Fort Ave. md.		25a. DATE REC'D. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE Julia Bender-Randall			

MEDICAL CERTIFICATION

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR

STAFF PHYSICIAN

DATE SIGNED

PHYSICIAN'S NAME

ADDRESS

DATE REC'D. BY REGISTRAR

REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

028683 DEC 31 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

My dear Mr. [illegible]  
I have just received your letter of the 14th inst. and am  
glad to hear that you are well and happy.

I am very busy at present, but I will try to  
write you again soon.

I am, dear Mr. [illegible], very  
truly yours,

[illegible signature]

[illegible text]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

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4 4 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) <b>OSCAR LEE BAYLY SR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 25 1986</b>		2b. HOUR <b>655 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 24, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>926 Rose Anne Rd. 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Bayly</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia Turner</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215 07 2409</b>		17. INFORMANT ADDRESS <b>Margaret L. Bayly (Same as 13a-e)</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Accid</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **arteriosclerosis**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12 17</b> , 19 <b>86</b> , to <b>12 25</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12 25</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>MUSTAFA C. OZ, M.D.</b>	DEGREE <b>MD</b>	22c. DATE SIGNED <b>12 26 86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
<b>MUSTAFA C. OZ, M.D.</b>		<b>605 BALTIMORE-ANNAPOLIS BLVD SEVERNA PARK, MARYLAND 21146</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Dec. 29, '86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Anne Arundel MD</b>
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1986</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

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28582-10-21

DATE

DECEMBER 25 1966

ADAMS COUNTY

ADAMS COUNTY HOSPITAL

DATE

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ADAMS COUNTY HOSPITAL

ADAMS COUNTY HOSPITAL

ADAMS COUNTY HOSPITAL

DEC 30 1966

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 within any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 33-50		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR		
12. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					Doc 9 1986					1:25 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		CAUCASION		Feb 2 1900		86		YRS.		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Balto MD		USA				Anne Arundel Co. MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Crownsville		Fairfield Arundel Nursing Center				Lawyer		Law.				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland					Anne Arundel		Severna Park		21146			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					13e. STREET ADDRESS / ZIP CODE		
John Beigel					Mary Shaeffer					288 North Dr Severna Park MD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
NO					212-070529		Lelia Beigel					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Dehydration + Cachexia										3 years		
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular accident stroke										3 years 8 mo		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from MAY 14 19 83 to Dec 9 19 86, that (I) (we) lost saw the deceased alive on Dec 9 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE T.C. Callis MD						DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		22c. DATE SIGNED Dec 9, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.C. Callis MD						22e. ADDRESS 7 Riggs Ave Severna Park MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 12-9-86		23c. NAME OF CEMETERY OR CREMATORY Westview Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE A.A. MD				
24. FUNERAL DIRECTOR Baraneco F.H. 501 Ritchie Hwy. Severna Park MD						25a. DATE REC'D BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE Julia Benson				

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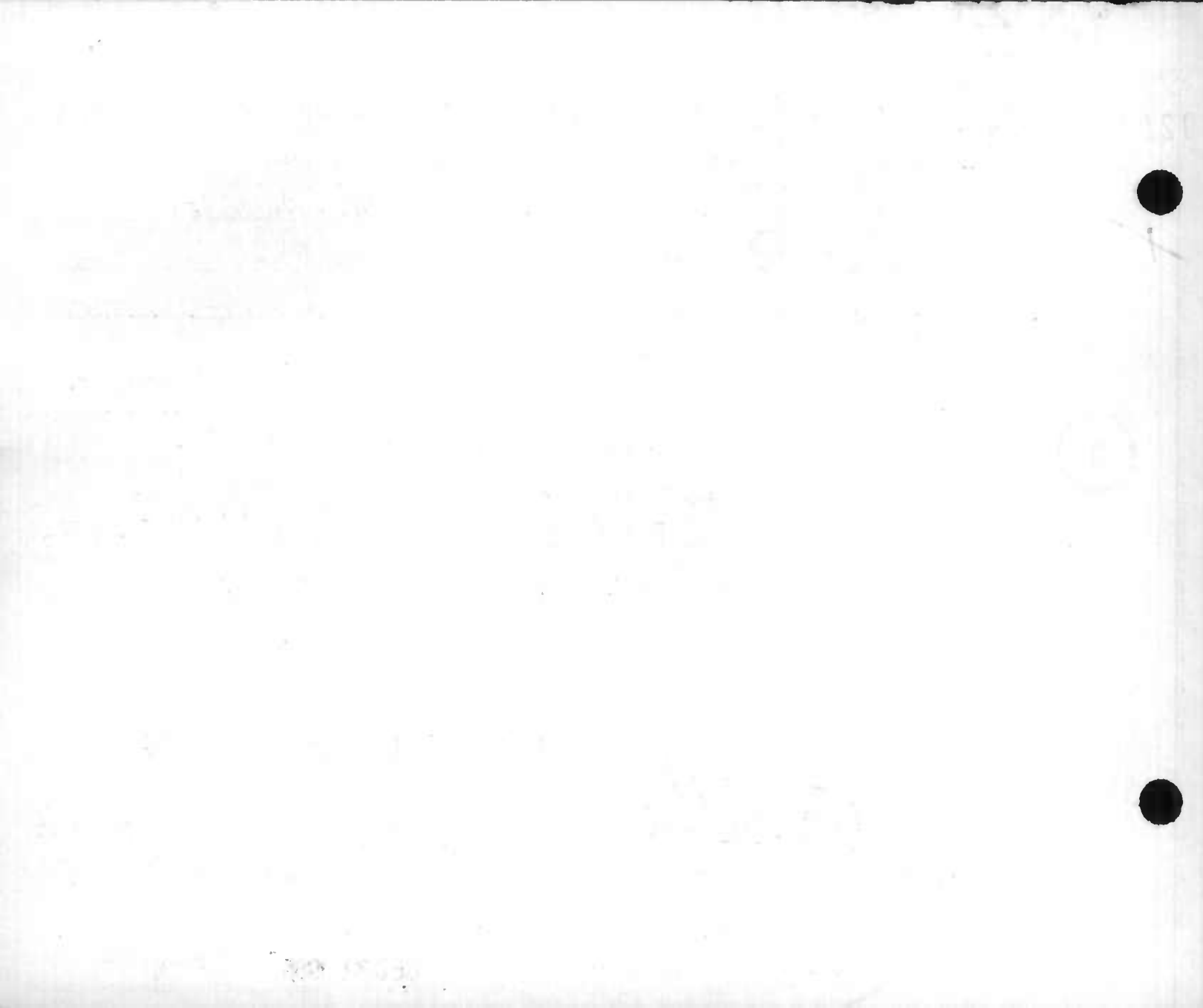
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <u>LILLIAN L BENNETT</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12-27-86</u>		2b. HOUR <u>4A</u> M		
3. SEX <u>FEMALE</u>		4. RACE <u>Wh</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>11 24 00</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>86</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>SE MARV'S CO</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>ANNE ARUNDEL</u> MD.	
10. CITY OR TOWN OF DEATH <u>BROOKLYN PK MD</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Medidian Hammonds LANE</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13a. STATE <u>Md.</u>		13b. COUNTY <u>AA</u>		13c. CITY OR TOWN <u>Glen Burnie</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <u>115 Central Ave. S.W. 21061</u>		14. FATHER'S NAME FIRST MIDDLE LAST <u>Daniel G. Stevens</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Margaret J. Shade</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO. <u>214-56-1737</u>		17. INFORMANT <u>John T. Bennett, Jr.</u>		ADDRESS <u>Glen Burnie, Md. 204 5th Ave. S.W.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SENILE DEMENTIA</u> 1976.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CEREBRAL VASCULAR INSUFFICIENCY.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>3/19/76</u> P.M. 19 <u>76</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED <u>12/27/86</u>		21h. DATE SIGNED	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/26/86</u> to <u>Dec. 27 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Harjit Singh</u> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. ADDRESS <u>#8, 16th AVENUE BALTIMORE, MD. - 21225.</u>		22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HARJIT SINGH</u> M.D.		22f. ADDRESS <u>BALTIMORE, MD. - 21225.</u>		22g. DATE SIGNED		22h. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>29 Dec. 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie AA Md.</u>	
24. FUNERAL DIRECTOR NAME <u>James S. Kirkley</u>		ADDRESS <u>Glen Burnie, Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 30 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Alia Decker-Rodgers</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove the top portion (Pages 1 and 2) and it should be filed with the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, it should not be removed from the certificate.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST <b>EDWARD T BENTS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/27/86</b>		2b. HOUR <b>5 AM</b>	
3. SEX <b>M</b>	4. RACE <b>C</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 7 01</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or Foreign) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>			
10. CITY OR TOWN OF DEATH <b>Severna Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) <b>Meridian Tag Center</b>		12a. USUAL OCCUPATION (Type of work or most of working life) <b>MAINTENANCE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>WEST. ELEC.</b>		
13a. USUAL RESIDENCE (If nursing home or other institution, give residence before admission) 13a. STATE <b>MD</b>	13b. COUNTY <b>A.A.CO.</b>	13c. CITY OR TOWN <b>Severna Park</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>24 Luchow Rd 21146</b>		
14. FATHER'S NAME (Type or Print) FIRST MIDDLE LAST <b>JOHN BENTS</b>		15. MOTHER'S MAIDEN NAME (Type or Print) FIRST MIDDLE LAST <b>BARBARA Cooper</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNKNOWN</b>		16b. SOCIAL SECURITY NO. <b>212090403</b>		17. INFORMANT ADDRESS <b>PASADENA, MD 21122</b> <b>ELIZABETH P. WEATHERSTEIN 760 209TH ST.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic cardiovascular</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>vascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>1</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SEPSIS</b>						
19a. DATE OF OPERATION <b>12/29/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SEPSIS</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, part 1 or part 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>5</b> 19 <b>84</b> , to <b>12/1</b> 19 <b>86</b> (shot (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dr E Kaplan, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12/29/86</b>		
22d. PHYSICIAN'S NAME (Type or Print)		22e. ADDRESS <b>21231</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 31, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOST HOLY REDEEMER</b>		
24. FUNERAL DIRECTOR NAME <b>LILLY &amp; ZIFLER, INC.</b>		ADDRESS <b>1901 EASTERN AVE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>		
25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Swenson-Pendall</b>				

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine Sellman Bias			2a. DATE OF DEATH MONTH DAY YEAR 12/5/86			2b. HOUR 2:14 PM	
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6/8/41		6. AGE (IN YEARS LAST BIRTHDAY) 45 yrs YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Arnold		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 109 Green Valley Dr.				12a. USUAL OCCUPATION (NAME OF WORK FIELDS OF WORKING (IFE) School Teacher	
12b. KIND OF BUSINESS OR INDUSTRY A.A. Co.		13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Arnold	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Sellman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Parker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-40-3116	
17. INFORMANT James E. Bias, Jr.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic colonic carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/28/86, 19, to 12/5/86, 19, that (I) (we) lost saw the deceased alive on 11/25/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stuart E. Selonick, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/5/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.		22e. ADDRESS 51 Franklin St. Annapolis, Md. 21014					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 12-10-86		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md.	
24. FUNERAL DIRECTOR NAME William Keese & Sons Mortuary		ADDRESS 821 West St.		25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE A. J. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits require carbon papers. Page 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Earl L. Blackman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DEC 17 1986</b>		2b. HOUR <b>6:23 PM</b>					
3. SEX <b>M</b>		4. RACE <b>C</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 7 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Rockingham, N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.				
10. CITY OR TOWN OF DEATH <b>ODENTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kimbrough Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>ODENTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>976 PATUXENT RD 21113</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Zeb Blackman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Spievey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>38-01-6303</b>		17. INFORMANT ADDRESS <b>Glen Sheppard 8605 Maple Ave. G.B.Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>congestive heart failure</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Gabrina Benjamin</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>17/12/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/20/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL MEM. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALT. MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HARDESTY FUNERAL HOME</b>			12. RIDGELY AVE. ADDRESS <b>ANN. MD. 21401</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 19 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julius Henderson</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. **IMPORTANT:** If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please return this page to the funeral director. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

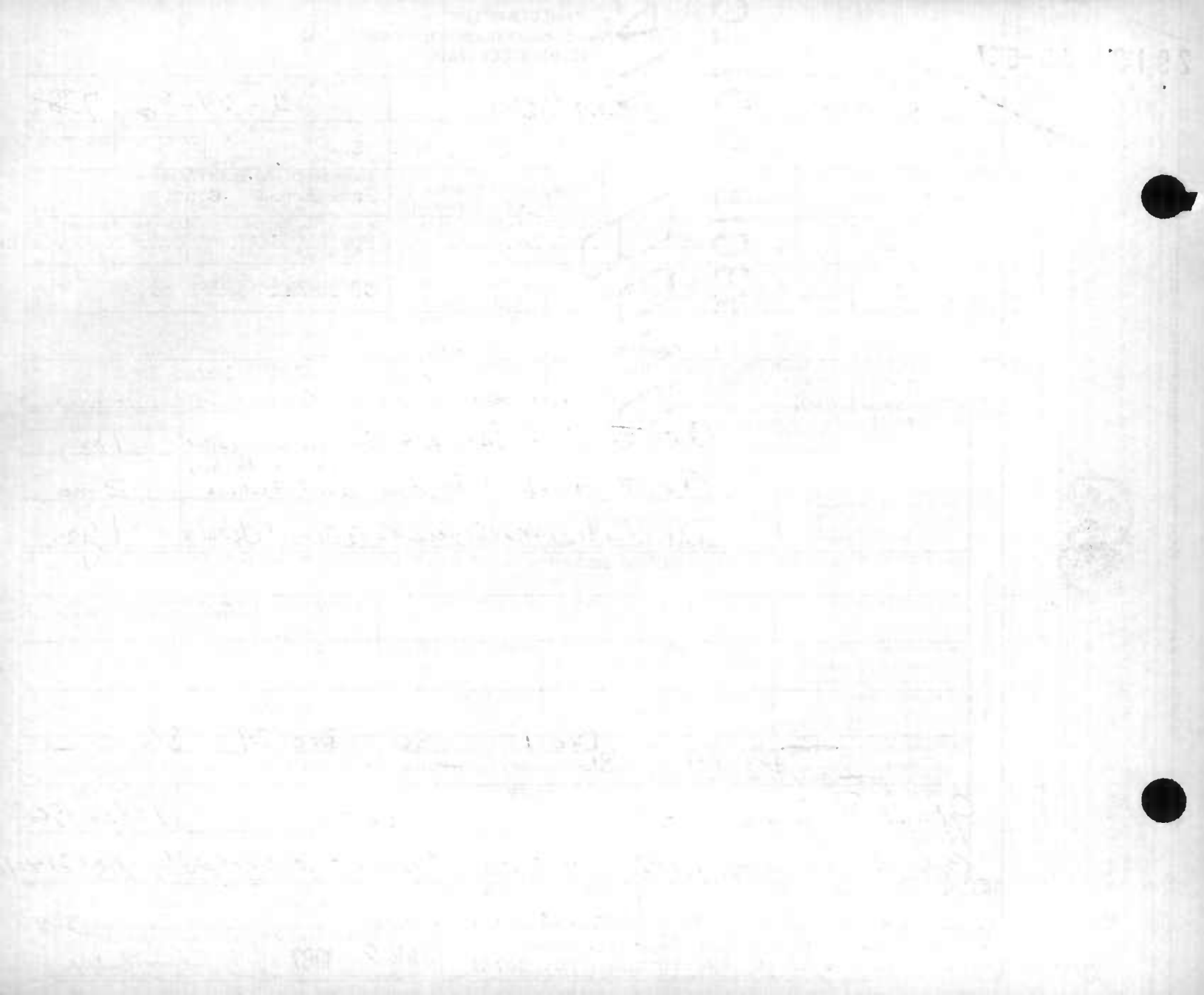
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME LAST <u>Delmar</u> FIRST <u>Thomas</u> MIDDLE <u>Boatman</u>			2a. DATE OF DEATH MONTH <u>12</u> DAY <u>24</u> YEAR <u>86</u>		2b. HOUR <u>7:30</u> M
3. SEX <u>Male</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH <u>February</u> DAY <u>11</u> YEAR <u>1920</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>66</u>	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel County</u> MD.		
10. CITY OR TOWN OF DEATH <u>Annapolis</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Postal clerk</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Anne Arundel</u> 13c. CITY OR TOWN <u>Crownsville</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>56 Sommer Hill Road 21032</u>	
14. FATHER'S NAME FIRST <u>Leonard</u> MIDDLE <u>Raymond</u> LAST <u>Boatman</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Susan</u> MIDDLE <u>Agnes</u> LAST <u>Laird</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>Yes-W.W.II Army</u>		16b. SOCIAL SECURITY NO. <u>170-12-8479</u>	17. INFORMANT (Son) <u>711 Amherst Road</u> <u>Thomas L. Boatman College Park, Md. 20740</u>		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pul. Edema + Chronic Congestive</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute and Chronic renal Failure</u> <u>Diabetes Mellitus - arterial disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>2 mo</u> <u>1 yr.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> <u></u> <u></u> <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the physician) attended the deceased from <u>Dec. 1</u> , 19 <u>86</u> , to <u>Dec. 24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Gary M. Richardson, M.D.</u>		DEGREE <u></u>		22c. DATE SIGNED <u>12/26/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GARY M. RICHARDSON, MD.</u>		22e. ADDRESS <u>104 Forbes Street Annapolis, Md. 21401</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>12/30/86</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maryland Veterans Cem.</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Cheltenham P.G. Maryland</u>		
24. FUNERAL DIRECTOR NAME <u>Francis Gasch's Sons Funeral Home, P.A.</u> ADDRESS <u>4739 Baltimore Avenue Hyattsville, Md. 20781</u>			25a. DATE REC'D. BY REGISTRAR <u>JAN 2 1987</u> 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 33 456  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Gilbert E. B. Rashears</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-22-86</b>			2b. HOUR <b>2250</b> M				
3. SEX <b>M</b>		4. RACE <b>C</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-16-01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GARDNER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1607 Orchard Beach Rd. 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GILBERT BRASHEARS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY SNOWDEN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-32-0502</b>		17. INFORMANT <b>Annapolis, Md. 21401</b> <b>MAUDE L. BRASHEARS 1607 Orchard Beach Rd.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for the final illness)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Respiratory failure**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)

**Diffuse atherosclerosis. Cerebral Vascular Accident.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>12/21</b> 19 <b>86</b> , to <b>12/22</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12/21</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>R. B. M. Hall M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/21/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-26-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ASBURY BROADNECK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Margarets A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1986</b>			
25b. REGISTRAR'S SIGNATURE <i>Julia Davis</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP \_\_\_\_\_

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Adam Deupert BROWN Sr.				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1986			
3. SEX Male				2b. HOUR 5:36 AM			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov 12, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 Terry Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maint. Super.		12b. KIND OF BUSINESS OR INDUSTRY B&A R.R.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST Franklin H. Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella G Cook			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 217.07.5796		17. INFORMANT Wife Margaret L. Brown		ADDRESS Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Resp Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 yr.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from JAN 1, 1983, to DEC 15, 1986, that (1) (we) last saw the deceased alive on DEC 10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Barry R. Nathanson M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Barry Nathanson M.D.				22e. ADDRESS 51 Franklin St. Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Dec. 17, 1986		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 16 1986		25b. REGISTRAR'S SIGNATURE Barry R. Nathanson	



REG. NO

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Viola		Jeanne		Brown				Dec		2		1986		1810A		M					
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR				IF UNDER 24 HRS					
Female		White		Feb 5 1903				83				MONTHS				DAYS					
								YRS				HOURS				MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH													
Pennsylvania		USA						Anne Arundel MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Crofton		Crofton Convalescent Center										Secretary				Legal					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE					
MD				AA				Annapolis				YES				1509 Riverdale Drive 21401					
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST								FIRST MIDDLE LAST													
Samuel Grob								Theresa Rest													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)								16b. SOCIAL SECURITY NO.				17. INFORMANT						ADDRESS			
NO -								215-28-0126				Barbara Clemens-						Same as #13			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Sepsis</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF	
	(b) <u>urinary tract infection</u>	
	DUE TO, OR AS A CONSEQUENCE OF	
	(c) _____	


PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY <table border="1"> <thead> <tr> <th>HOUR</th> <th>A.M.</th> <th>MONTH</th> <th>DAY</th> <th>YEAR</th> </tr> </thead> <tbody> <tr> <td></td> <td>P.M.</td> <td></td> <td></td> <td>19</td> </tr> </tbody> </table>	HOUR	A.M.	MONTH	DAY	YEAR		P.M.			19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
HOUR	A.M.	MONTH	DAY	YEAR								
	P.M.			19								

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					

22a. I certify that (I) (this hospital) attended the deceased from 11/11, 1985, to 12/5, 1986, that (I) (we) last saw the deceased alive on 12/3, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

21c. SIGNATURE  DEGREE \_\_\_\_\_

ATTENDING ☒ MEDICAL ☒ STAFF  
PHYSICIAN ☐ DIRECTOR ☐ PHYSICIAN ☐

22c. DATE SIGNED 12/3/86

22a PHYSICIAN'S NAME (TYPE OR PRINT)	22b ADDRESS
Paul G Berez MD	P.O. Box 3491 Clopton MD 21114

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec 6 1986	23c. NAME OF CEMETERY OR CREMATORY St Anne's	23d. LOCATION CITY OR TOWN Annapolis	COUNTY An	STATE MD
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24. FUNERAL DIRECTOR:	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
TAMMOR FUNERAL HOME ADDRESS: BOSTON, MA	DEC 3 1986	Julia Sanders-Rodale

## MEDICAL CERTIFICATION

BP\_\_\_\_\_

DHMH - 16 60M 7/B4  
(VRA 15, 4)

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

028000 00-10

1

CUSTOMER LISTED



Box 1

*[Faint, mostly illegible handwritten text and markings covering the lower half of the page. Some words like "Box 1" and "CUSTOMER LISTED" are visible.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANN B. BUCHANAN			2a. DATE OF DEATH MONTH DAY YEAR 12 5 86		2b. HOUR 12:50 A
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 12 25 1916	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 733 Best Gate Rd.		12a. USUAL OCCUPATION (GIVE USUAL OR MOST OF WORKING (IFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY State	
13a. STATE Md.		13b. CITY OR TOWN A.A. Annapolis	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 733 Best Gate Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Parker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann M. Gantt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-26-1036	17. INFORMANT ADDRESS Annapolis, Md, 21401 Carol S. Council - 733 Best Gate Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SCLERODERMA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.					
22b. SIGNATURE James M. Blake MD		DEGREE		22c. DATE SIGNED 12/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES M. BLAKE MD		22e. ADDRESS 171 DEFENSE HIGHWAY ANNAPOLIS, MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-8-86	23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md.	
24. FUNERAL DIRECTOR NAME William Keeseversons Mortuary-821 West St		25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>EARL WILBUR BUDDEMEIER</b>				20. DATE OF DEATH MONTH DAY YEAR <b>DEC. 3, 1986</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 7, 1916</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Gen. Hosp.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING AGE) <b>ELECTRICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		13. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY W. BUDDEMEIER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EDNA MARY STEVENS</b>		16. SOCIAL SECURITY NO. <b>213-10-5702</b>		
17. INFORMANT ADDRESS <b>ELIZABETH W. BUDDEMEIER #13</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Large tumor with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/1, 1983</b> to <b>12/3, 1986</b> , that (I) (we) last saw the deceased alive on <b>12/3, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)						
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. I. Hochman, M.D.</b>				22c. ADDRESS <b>16 Murray Ave, Annapolis, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/8/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>		
24. FUNERAL DIRECTOR NAME <b>TAYLOR FUNERAL CHAPEL</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 11 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John Henderson</i>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 4 6 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BETTY LOU BURGESS			2a. DATE OF DEATH MONTH DAY YEAR 12 2 86			2b. HOUR 6:00 a.m.				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 4 29 36		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		7. # UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1819 Dorsey Road 21061				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker		
13a. STATE Maryland			13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1819 Dorsey Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Louis H. Affeldt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Kelbo							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 32 0580		17. INFORMANT Glen Burnie, Maryland 21061 Louis H. Burgess 1819 Dorsey Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>left ventricular failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>hrs.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>1/5</i> 19 <i>76</i> to <i>12/2</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>12/2</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Max C. Frank</i> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C FRANK MD			DEGREE MD 22c. DATE SIGNED 12/3/86			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/5/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME Raymond C. Fink Glen Burnie, Md. 21061					25a. DATE REC'D. BY REGISTRAR DEC 3, 1986		25b. REGISTRAR'S SIGNATURE <i>John J. ...</i>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remember to return page 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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EST

1. FOR  
STATE  
REGISTRAR

REG. NO.

DECEASED NAME

FIRST

MIDDLE

LAST

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

THOMAS

E.

BUTLER Sr.

DECEMBER 24, 1986

625 PM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

11/6/1900

6. AGE (IN YEARS LAST BIRTHDAY)

86

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

ANNE ARUNDEL COUNTY

MD.

10. CITY OR TOWN OF DEATH

GLEN BURNIE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

NORTH ARUNDEL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Insurance Agt. Prudential

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

---

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

3809 Brooklyn Ave. 21225

14. FATHER'S NAME

Thomas

M.

Butler

15. MOTHER'S MAIDEN NAME

Margaret

Link

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

212-07-3037

17. INFORMANT

ADDRESS

Estella C. Butler Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia

DUE TO OR AS A CONSEQUENCE OF

(b) ASACD

DUE TO OR AS A CONSEQUENCE OF

(c) Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Arteriosclerosis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-17, 19-86, to 12-24, 19-86 that (I) (we) lost saw the deceased alive on 12-24, 19-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MUSTAFA C. OZ, M.D.

22e. ADDRESS

605 BALTIMORE-ANNAPOLIS BLVD SEVERNA PARK, MARYLAND 21146

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12/27/86

23c. NAME OF CEMETERY OR CREMATORY

Glen Haven Mem Pk

23d. LOCATION

Glen Burnie

COUNTY

AA Co., STATE

Md.

24. FUNERAL DIRECTOR

NAME

237 E. Patapsco Ave.

ADDRESS

McCully Funeral Homes Balto.Md.21225

25a. DATE REC'D. BY REGISTRAR

DEC 30 1986

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

08030

029628 JAN 16 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a. DATE KNOWN OF DEATH ESTI- MATED			MONTH DAY YEAR			2b. HOUR							
Timothy William Carter						X			12/ 30 / 1986			M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		White		3 - 26 - 70		16 YRS.		MONTHS		DAYS		12/31/ 1986		6:20 PM					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				United States								Anne Arundel County, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Severna Park				Severn River				Student				High School							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Anne Arundel		Severna Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14 Kimberly Court/21146									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
Walter C. Carter				Mary V. Rice															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
No				214 06 7366				Walter Carter (Same as # 13)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 8309 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				2:00 P.M. 12/30/ 1986				subject drowned when boat capsized											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
				water				Severn River, Severna Park, Anne Arundel, Md.											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
TITLE (SPECIFY) M. Deputy Chief MEDICAL EXAMINER																			
ACTUAL SIGNATURE				Ann M. Dixon, M.D.				ADDRESS				DATE SIGNED							
				111 Penn St.								1/1/87							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				1 - 3 - 87		Meadowridge Cemetery				Dorsey, Howard, MD									
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
ROBERT S. BARRANCO										JAN 09 1986					Julia Dixon-Rodman				
SEVERNA PARK, MD. 21146																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M

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(VR A15 ME (5))



027828 DEC 23 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner will be contacted at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8633464			
1. DECEASED NAME (TYPE OR PRINT) Edward Harold Champ				2a. DATE OF DEATH MONTH DAY YEAR 12-17-86			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-8-1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Post Office		12b. KIND OF BUSINESS OR INDUSTRY USGov.	
13a. STATE Md.		13b. COUNTY AA Co.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 79 Summerhill Rd. 21032		14. FATHER'S NAME FIRST MIDDLE LAST Walter J. Champ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Marley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII		17. INFORMANT Fumi F. Champ		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 hour</u> <u>1 hr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>HYPERTENSION</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-17-78</u> , 19____, to <u>12-17-86</u> , 19____, that (I) (we) lost saw the deceased alive on <u>12-4-86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-17-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lara		22e. ADDRESS 9326 Lanham <u>MD 20706</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-19-86		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION Balt. CITY OR TOWN Balt. COUNTY Md. STATE	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Annapolis Md.				25a. DATE REC'D. BY REGISTRAR <u>DEC 19 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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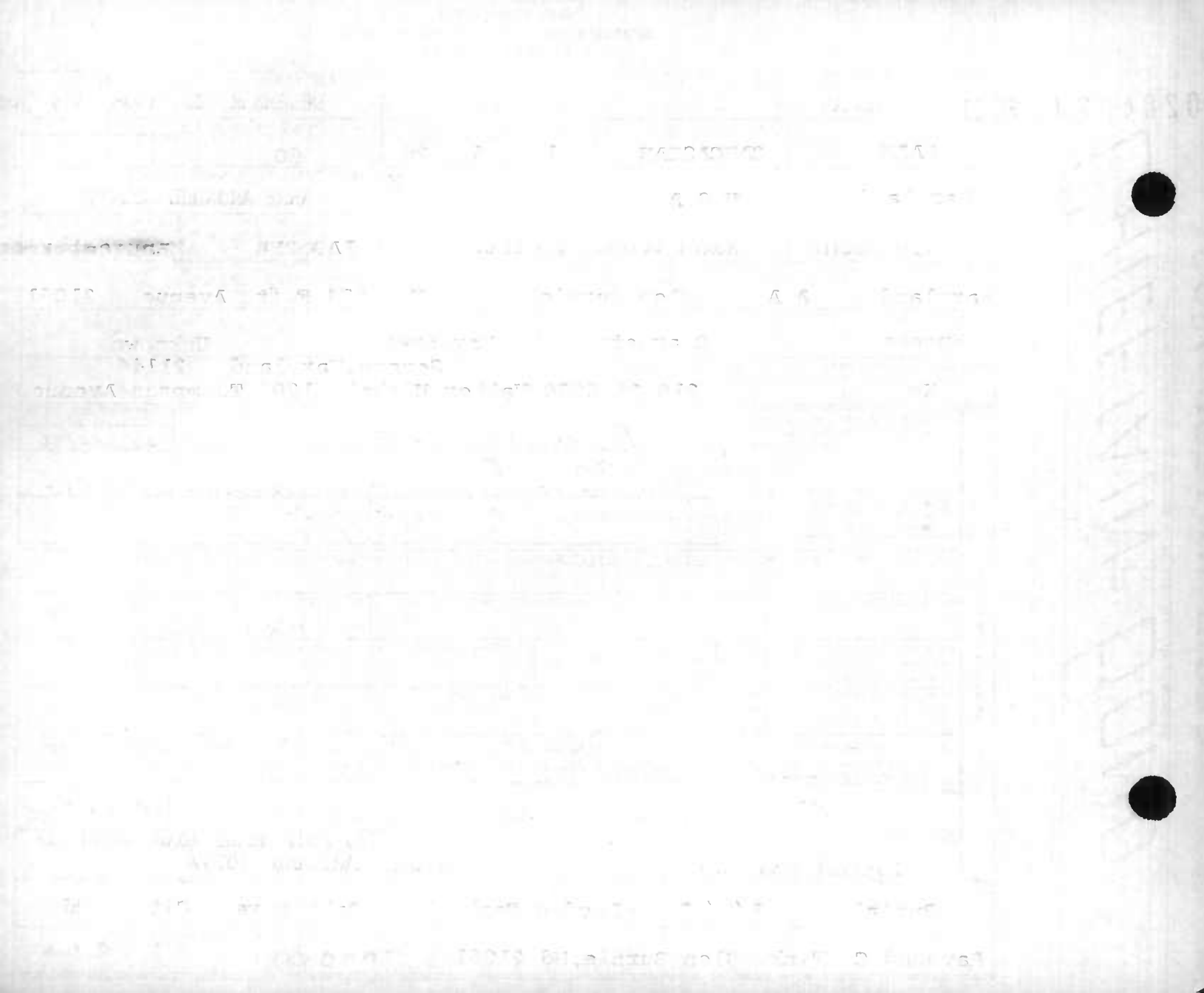
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROMAN C CHARNETZ			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1986			2b. HOUR 345 AM		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 1 6 26		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
13a. STATE Maryland				13b. COUNTY A A		13c. CITY OR TOWN Glen Burnie		
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Charnetz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 22 5939		17. INFORMANT Severn, Maryland 21144 Walter Nickel 1206 Thompson Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>far advanced oat cell carcinoma of the lung.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 M.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>Dec 12</u> 19 <u>86</u> , to <u>Dec 28</u> 19 <u>86</u> , that (1) <del>the</del> last saw the deceased alive on <u>Dec 27</u> 19 <u>86</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (we) (did) <del>not</del> view the body after death.								
22b. SIGNATURE <u>Dr. HSLU Hung, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/28/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PO-HSLU HUNG, M.D.				22e. ADDRESS 5450 FORT MEADE ROAD, ROOM 207 LAUREL, MARYLAND 20707				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/2/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md		
24. FUNERAL DIRECTOR NAME Raymond C. Fink				ADDRESS Glen Burnie, Md 21061		25a. DATE REC'D. BY REGISTRAR DEC 29 1986		
				25b. REGISTRAR'S SIGNATURE <u>Richard P. Pender</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



026779 DEC 11 1986

STATE OF MARYLAND

33466

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Robert Joseph Charron, Jr.								12/ 7/ 1986		12/ 7/ 1986		6:39 P M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Male	White	4-11-68		18 YRS.						12/ 7/ 1986		6:39 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Anne Arundel County MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Glen Burnie		North Arundel Hospital		Carpenter		Construction							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.				A.A. Co.		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1308 Tuggies Rd.		21122	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Robert Joseph Charron Sr.				Linda Lee Barrett									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO				220-70-0047		Robert J. Charron Sr		same as 13 e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound of Head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? HEAD <input checked="" type="checkbox"/> ONLY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>5:44</u> P.M. MONTH <u>12</u> DAY <u>7</u> YEAR <u>1986</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>self inflicted wound</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>home</u>				21f. LOCATION STREET <u>1308 Tuggies Rd.</u> CITY OR TOWN <u>Pasadena</u> COUNTY <u>Anne Arundel</u> STATE <u>Md.</u>					
22a. I certify that I took charge of the remains described above and only Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
<u>Gregory R. Kauffman, M.D.</u>				M.D. Assistant MEDICAL EXAMINER				12/8/86					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Gregory R. Kauffman, M.D.				111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial				12/11/86		Cedar Hill Cemetery		Brooklyn		A.A.		Md.	
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George J. Gonce				4001 Ritchie Hgwy Balto Md.		DEC 9 1986		Julia Swinton-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 86 33461				
1. DECEASED NAME (TYPE OR PRINT) <b>William Alexander Chase, Sr</b>					2a. DATE OF DEATH MONTH <b>Dec</b> DAY <b>19</b> YEAR <b>1986</b> 2b. HOUR <b>P.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>Apr</b> DAY <b>12</b> YEAR <b>1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 72 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A. Co</b> MD			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1115 Madison St-</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Janitor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
13a. STATE <b>md</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1115 Madison - 21403</b>	
14. FATHER'S NAME FIRST <b>Alfred</b> MIDDLE <b></b> LAST <b>Chase</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b> MIDDLE <b></b> LAST <b>Tootles</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-32-0671</b>		17. INFORMANT ADDRESS <b>ANNIE KELLY 1115 Madison ST</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Atherosclerosis</b>									
(c) <b></b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>2 May</b> 19 <b>79</b> to <b>26 Nov</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>26 Nov</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or) (did not) view the body after death.									
22b. SIGNATURE <b>Jon B. Lowe</b> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>23 Nov 86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jon B. Lowe md</b>					22e. ADDRESS <b>77 West St - ANNAPOLIS, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-24-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn Mem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNAPOLIS A.A. md</b>			
24. FUNERAL DIRECTOR NAME <b>C.S. Hicks</b> ADDRESS <b>1922 Forest Drive</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 29 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Benson-Randall</b>		

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*[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove signature papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>VICTOR E. CLAPSADDLE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 24 86</b>			2b. HOUR <b>5:59P.M.</b>			
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 25 90</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AnneArundel Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>Crownsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairfield Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>gauge inspector</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tool Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>AnneArundel</b>		13c. CITY OR TOWN <b>Crownsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>331 S. Riverside Dr. 21032</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Tramuel R. Clapsaddle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Kuhn</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>173-03-0567</b>		17. INFORMANT <b>510 Sunnybrook Cr. W. Ormond Beach, Mr. Victor E. Clapsaddle Jr. Fla. 32074</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>aged</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 1982</b> to <b>December 24 1986</b> , that (I) (we) lost saw the deceased alive on <b>December 24 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John D. Skarbak</b>				DEGREE <b>MD.</b>			22c. DATE SIGNED <b>12-24-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John D. Skarbak</b>				22e. ADDRESS <b>3708 Mountain Rd Pasadena Ar 91107</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/27/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waynesboro, Franklin Pa.</b>			
24. FUNERAL DIRECTOR <b>Sam Year</b>				ADDRESS <b>Pa. 17268 50 S. Broad St. Waynesboro,</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>KATHERINE C CLARK</b>			2a. DATE OF DEATH MONTH <b>DECEMBER</b> DAY <b>21</b> YEAR <b>1986</b>		2b. HOUR <b>1330 PM</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>4</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>F.</b> LAST <b>Bauer</b>			15. MOTHER'S MAIDEN NAME FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>213-32-6145</b>		17. INFORMANT <b>William E. Bender</b> ADDRESS <b>212 Hickory Point Rd.-Pasadena, Md. #21122</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Septicemia &amp; cerebrovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-11</b> , 19 <b>86</b> , to <b>12-21</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12-21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L. SEENIVASAN, M.D.</b>				22c. DATE SIGNED <b>12/21/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. SEENIVASAN, M.D.</b>				22e. ADDRESS <b>606 HAMMONDS LANE BALTIMORE, MARYLAND 21225</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 24, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Pk. Cem.</b>	
23d. LOCATION CITY OR TOWN <b>Balto.</b>		COUNTY <b>Balto.</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR <b>G. Truman Schwab</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Bender-Pudner</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

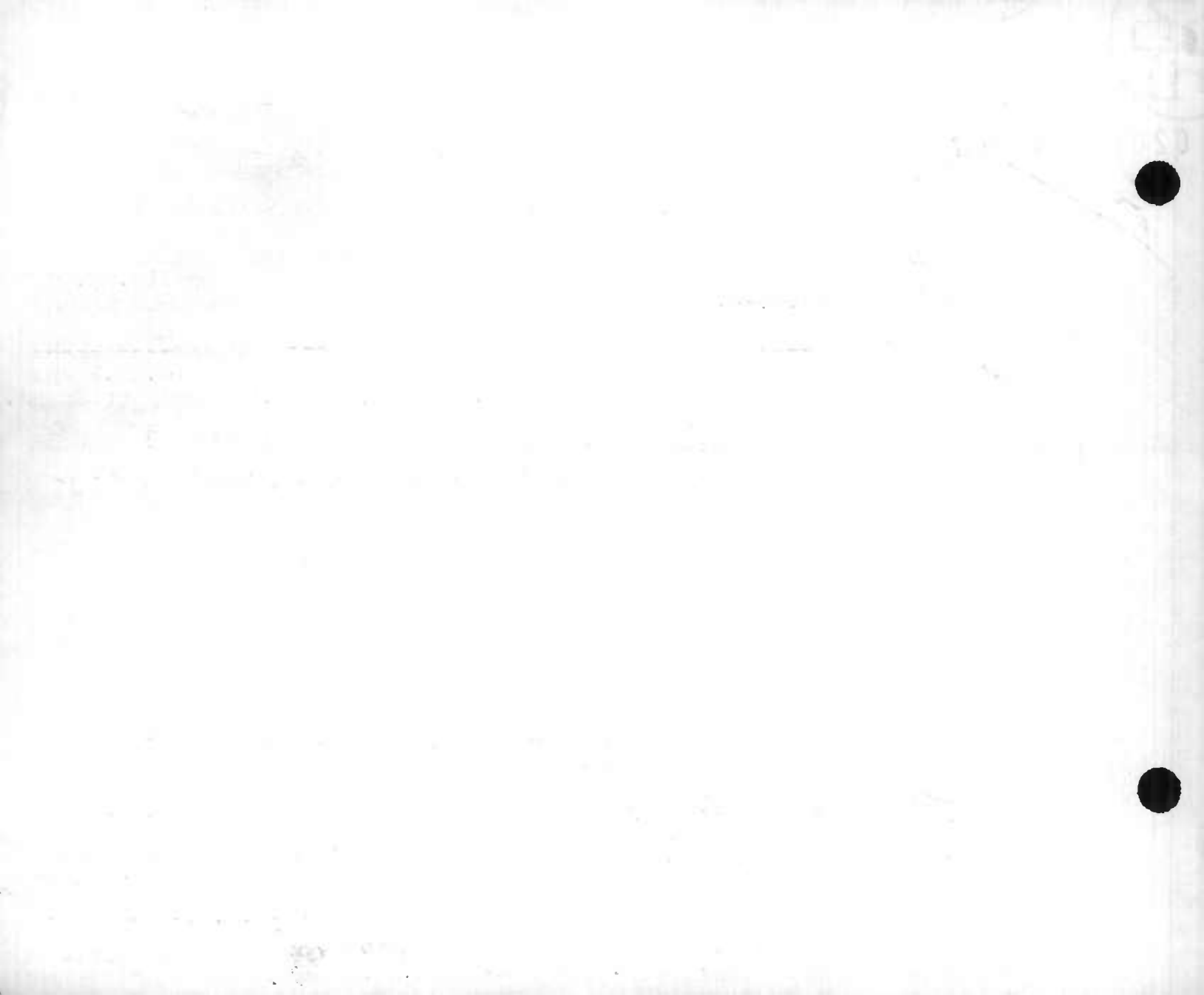
1. DECEASED NAME (TYPE OR PRINT) <i>Catherine Louise Cookus</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 22 86</i>			2b. HOUR <i>2:55 A</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 1 98</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>U.S.-W. VA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Glen Burine A.A.Co., MD.</i>			
10. CITY OR TOWN OF DEATH <i>MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hammond Lane Meridan</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>				13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Balto</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John --- Timmons</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary --- Conners Timmons</i>				13e. STREET ADDRESS / ZIP CODE <i>Balto. Md. 21230</i> <i>1725 S. Charles St.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-74-484</i>		17. INFORMANT ADDRESS <i>Mr. David T. Cookus, 516 Holy Cross Rd. Balto. Md. 21225</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cerebro Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cerebral Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>10-6</i> 19 <i>83</i> , to <i>12-22</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>12-22</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Rolando V. Goco, M.D.</i>				DEGREE				22c. DATE SIGNED <i>12-23-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rolando V. Goco, M.D.</i>				22e. ADDRESS <i>707 E. Fort Avenue, Balto. Md. 21220</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/24/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemt.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. A.A.Co. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Home</i>				ADDRESS <i>Balto. Md. 21230</i> <i>130 E. Fort Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 30 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Tindem-Randall</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or cremation. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified of cause.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 33471	
1 - FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) Anne E. Hudye				2a. DATE OF DEATH MONTH DAY YEAR December 25, 1986		2b. HOUR 12:00 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8105 Phirne Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8105 Phirne Rd. 21061			
14. FATHER'S NAME FIRST MIDDLE LAST Steve Lucas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Horiyak							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 208-10-0323		17. INFORMANT ADDRESS Carol Barron same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Esophageal Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multifocal Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophageal Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 year</u> <u>5 years</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>12/15</u> , 19 <u>86</u> , to <u>12/25</u> , 19 <u>86</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>12/15</u> , 19 <u>86</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.										22c. DATE SIGNED 26 Dec. 86	
22b. SIGNATURE <u>Elliott Gorbaty</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elliott Gorbaty M.D.				22e. ADDRESS 7845 Oakwood Rd., Glen Burnie, MD 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29 Dec. 86		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Windber PA.					
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD 21061				25a. DATE REC'D. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE <u>Eric Bender-Randall</u>					



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
500 Clodfelter, John								12 8 86		2035 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
M		White		8 19 19		67 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
N. Carolina		U.S.				A. Arundel County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		A. Arundel Hosp.				Guard		Security			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		1862 Generals Hwy. 21401			
Md.		A. Arundel									
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Jay Clodfelter				Fannie Lackey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		1862 ADDRESS Generals Hwy.			
Yes				WWII		579-05-4528		Ms. Carol A. Donaldson Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) BRAIN ANOXIA										3 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIO RESPIRATORY ARREST										3 minutes	
DUE TO, OR AS A CONSEQUENCE OF (c) SPINAL CORD Trauma 2° to Cervical INTJURY & TETRAPLEGIA										72 H	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
Degenerative Cervical Disk Disease; coronary artery disease; h/o DCA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/2/86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fall in bathtub 2-3 d prior to admission							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1862 Generals Hwy Annapolis Md 21401							
22a. I certify that (this hospital) attended the deceased from 12/5/86 to 12/8/86, that (we) last saw the deceased alive on 12/8/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE Cy Gordon MD		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/8/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW GORDON MD		22e. ADDRESS 1657 Crofton Blvd Crofton Md 21114									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12-10-86		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
				////////							
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		25a. DATE RECEIVED BY BURIAL OR CREMATION DEC 12 1986			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

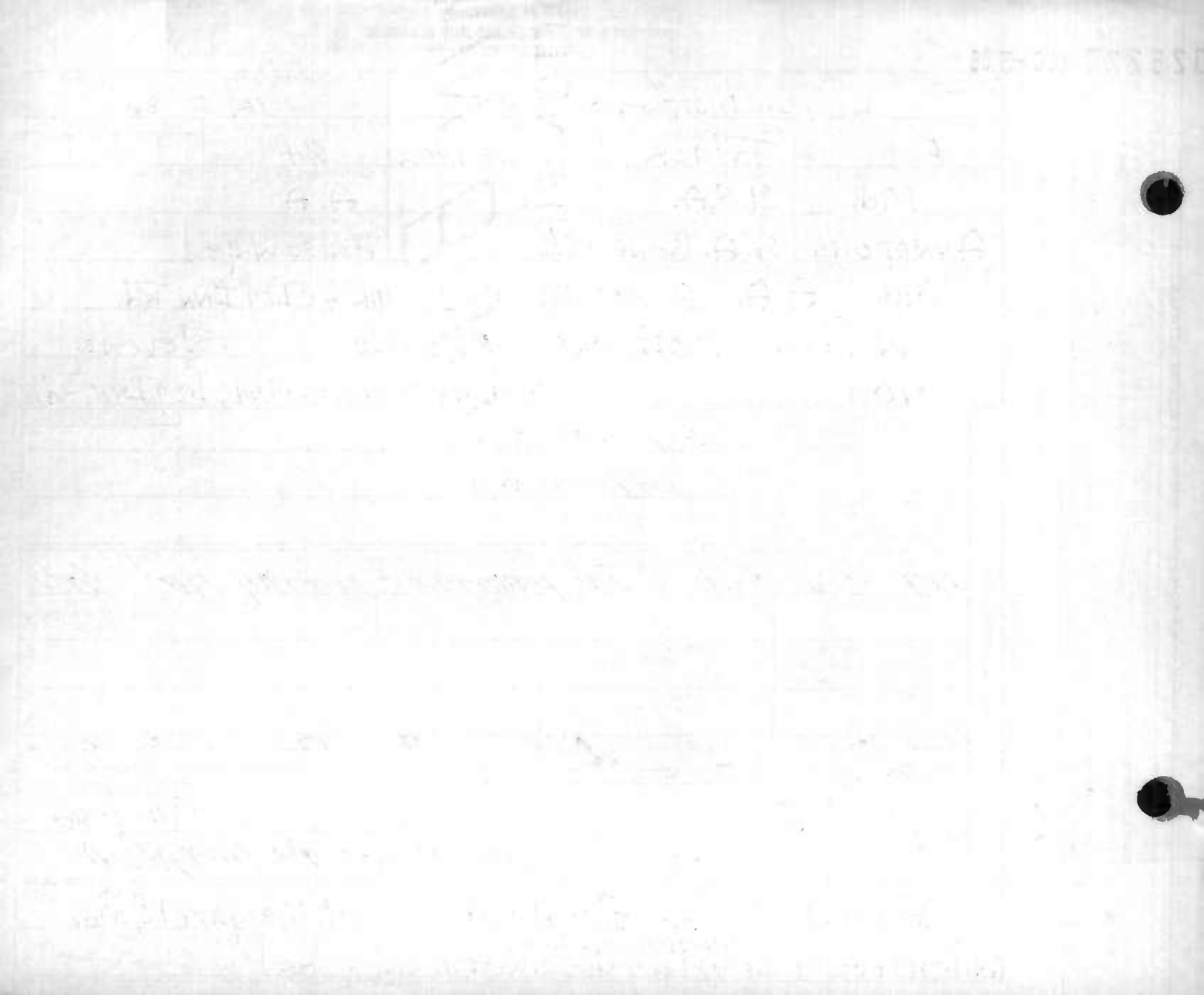
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louise Matthews Coates</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 2 86</i>			2b. HOUR M <i>M</i>			
3. SEX <i>F</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 13 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>A.A.</i> MD.			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>A.A. General</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1454C Log Inn Rd. 21401</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Matthews</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Phoebe Stevens</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Helen Stevens-1454C Log Inn Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Deep seated decubitus ulcer pneumonia, urinary tract infection</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>11/29</i> , 19 <i>86</i> , to <i>12</i> , 19 <i>86</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>12-2</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>G.A. Mitchell</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>12-3-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gregory A Mitchell</i>				22e. ADDRESS <i>205 Ridgely Ave Annapolis</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/6/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>St. Margarets, Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>William M. Reese &amp; Sons Mortuary, 14821 West St</i>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 3 3 4 7 4  
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) CARRIE COLLINS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 17, 1986		2b. HOUR 1 00 AM										
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.									
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Anne Arun.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 915 Hammonds Ln. 21225			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Tinker						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 212 56 9780		17. INFORMANT ADDRESS Frederick Collins (same as 13a-e)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio. coronary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Aortic Coronary DUE TO, OR AS A CONSEQUENCE OF (c) Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ① Aneurysm ② CVA ③ Coronary															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET 12/10		CITY OR TOWN 12/17		COUNTY 1986		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/10 1986 to 12/17 1986, that (I) (we) last saw the deceased alive on 12/17 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE FELIX M. GAYOSO, M.D.				DEGREE M.D.				22c. DATE SIGNED 12/18/86				22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5411 OLD FREDERICK ROAD BALTIMORE, MARYLAND 21229	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 19 '86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN Baltimore		COUNTY A.A.		STATE MD	
24. FUNERAL DIRECTOR NAME McCully Funeral Homes				24b. ADDRESS 237 Potapsc Ave. Baltimore, MD				25a. DATE REC'D. BY REGISTRAR DEC 19 1986				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



28441 DEC 30 1986

1. DECEASED NAME (TYPE OR PRINT) JAMES Thomas COLLINS, Sr		2a. DATE OF DEATH MONTH DAY YEAR 12-17-86		2b. HOUR 4:30 PM
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 7-3-27		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Equipment Operator	
12b. KIND OF BUSINESS OR INDUSTRY ST Hgwy.	13a. STREET ADDRESS / ZIP CODE 1229 Wrighten Rd 20711			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Thomas COLLINS	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. 1 Korean 220-36-9427	17. INFORMANT ADDRESS Ruth R. Collins 1229 Wrighten Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Small Cell Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/5 1986, to 12/17 1986, that (I) (we) last saw the deceased alive on 12/17 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE E.W. Collins		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.W. COLE III		22e. ADDRESS 51 FRANKLIN ST. ANNAPOLIS MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-22-1986	23c. NAME OF CEMETERY OR CREMATORY Moses	23d. LOCATION CITY OR TOWN COUNTY STATE Drury A.A. MD	
24. FUNERAL DIRECTOR NAME C.E. Hicks		25a. DATE REC'D. BY REGISTRAR DEC 29 1986		25b. REGISTRAR'S SIGNATURE Julia Tindon-Rudolph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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A. A.

026619 DEC 10 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDGAR LEE COLLISON Sr.</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 12 7 1986				2b. HOUR 4 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 18, 1925	6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD December 7 1986		2d. HOUR 4 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) A B C Baggage		12b. KIND OF BUSINESS OR INDUSTRY Air Port	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland		13b. CITY OR TOWN A A Co.		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST Pomroy E. Collison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Lowman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WWII			
16b. SOCIAL SECURITY NO. 213.20.8660				17. INFORMANT Deborah M. Perkins		ADDRESS 289 Maxo Court Glen Burnie, Md. 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ATHERO SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>TURBACCO ABUSE</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Charles Seager</b>				TITLE (SPECIFY) M.D. <b>DEPUTY</b> MEDICAL EXAMINER				DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT) <b>CHARLES SEAGER</b>				ADDRESS <b>780 RITCHIE HWY, SU PK</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 11, 1986		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A A Co. Md.			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home				Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 9 1986		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

05 OCT 1960 10 10 00

TO: DIRECTOR, FBI (100-37150) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY, AKA; ALLEGED ATTEMPT TO OBTAIN PASSPORT FOR TRIP TO AFRICA

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER 5, 1960.

ADVISE THAT JAMES EARL RAY, AKA, ADVISED THAT HE HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERS HIMSELF AS A TRAVEL AGENT, THAT HE COULD OBTAIN A PASSPORT FOR TRIP TO AFRICA.

ADVISE THAT RAY STATED THAT HE HAD BEEN ADVISED THAT HE COULD OBTAIN A PASSPORT FOR TRIP TO AFRICA.

ADVISE THAT RAY STATED THAT HE HAD BEEN ADVISED THAT HE COULD OBTAIN A PASSPORT FOR TRIP TO AFRICA.

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ADVISE THAT RAY STATED THAT HE HAD BEEN ADVISED THAT HE COULD OBTAIN A PASSPORT FOR TRIP TO AFRICA.

027151 DEC 3 1986

DIVISION OF VITAL RECORDS, 203 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 4 7 1

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR M	
EDITH ESKESEN COMBS			DEC. 10, 1986				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.	
female		white		Dec. 17, 1898		87	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.	
N.J.		U.S.A.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
ANNAPOLIS		ANNAPOLIS NURSING & CONV.				CEN. HOUSEWIFE	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD.		A.A.		ANNAPOLIS		539 SECOND ST. 21403	
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
BENNET ESKESEN			GUNDEL CARLSON				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
NO			216-46-8118		EDITH SCHMIDT SAME AS 13		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21a PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from 19 18 to 10 Dec 19 86, that (I) (we) last saw the deceased alive on 5 Dec 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10 Dec 86	
22a PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		DEC. 12, 1986		DRUIDE RIDGE CEM		BALTIMORE MD	
24 FUNERAL DIRECTOR NAME ADDRESS				25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE			
HARDESTY FUNERAL HOME 12 Ridgely Ave. Ann. MD				DEC 12 1986 <i>[Signature]</i>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>JOHN</u> <u>F.</u> <u>CONNOLLEY</u>			2a. DATE OF DEATH MONTH <u>12</u> DAY <u>23</u> YEAR <u>86</u>			2b. HOUR <u>4:05 PM</u>					
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>October</u> DAY <u>10</u> YEAR <u>1942</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>44</u> YRS		7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		8. IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Balt., Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel Co.</u> MD.					
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>1551 Shipview Rd.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Self-Employed</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u>		13b. COUNTY <u>A.A.</u>		13c. CITY OR TOWN <u>Annapolis</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>1551 Shipview Rd./21401</u>			
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>F.</u> LAST <u>Connolley Sr.</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Thelma</u> MIDDLE <u>R.</u> LAST <u></u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>220-36-9391</u>		17. INFORMANT ADDRESS <u>Karen Connolley (same as 13)</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Resp Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Approx 2 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>9-28</u> 19 <u>86</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u>51 FRANKLIN ST.</u>		CITY OR TOWN <u>ANNAPOLIS</u>		COUNTY <u>A.A.</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-28</u> , 19 <u>86</u> , to <u>12/23</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>12-11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Barry R. Nathanson</u> (FOR DR. E. COLE)				DEGREE <u>ATTENDING PHYSICIAN</u>				MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/24/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY R. NATHANSON</u>				22e. ADDRESS <u>51 FRANKLIN ST. ANNAPOLIS MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>12-27-1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakemont Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Davidsonville</u>		COUNTY <u>A.A.</u>	
24. FUNERAL DIRECTOR NAME <u>ROBERT S. BARRANCO</u>				ADDRESS <u>SEVERNA PARK, MD. 21146</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 29 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

BP

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SEVERNA PARK MD. 21146  
ROBERT A. BARBARO

029514 JAN-087

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SAMUEL L. COOK, Sr.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 22, 1986			2b. HOUR 11:14 A.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 27, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) 18 WOODLAWN				12a. USUAL OCCUPATION (IF OTHER THAN MOST OF WORKING LIFE) PLUMBER STATE	
12b. KIND OF BUSINESS OR INDUSTRY OF MARYLAND							

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN MARYLAND ANNE ARUNDEL ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 713 BESTGATE RD. 21401	
14. FATHER'S NAME ERNEST G. COOK			15. MOTHER'S MAIDEN NAME DORA STEPHENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (ES. NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-03-3881		17. INFORMANT ADDRESS SAMUEL L. COOK, Jr.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic lung carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	---	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>brain metastatic tumor</i>			
--	--	--	--

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/17</i> 19 <i>86</i> to <i>12/22</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>11/17</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.							
22b. SIGNATURE <i>Paul Perez</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Perez MD		22e. ADDRESS 1655 Custer Blvd Box 3491 Custer MD 21114					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-24-86		23c. NAME OF CEMETERY OR CREMATORY HILLCREST ANNAPOLIS		23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL MARYLAND	
24. FUNERAL DIRECTOR ROBERT E. EVANS ANNAPOLIS, MARYLAND				25a. DATE REC'D. BY REGISTRAR JAN 8 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other fatal event, the medical examiner must be notified at once.

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BP

DHMH - 16 60M 7/84  
(VRA 15, 4)FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 4 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILBUR H. COOK			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1986		2b. HOUR 1740 M
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR April 22, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Fort Meade A.A. MD.	
10. CITY OR TOWN OF DEATH Fort Meade	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Soldier	12b. KIND OF BUSINESS OR INDUSTRY Military	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Jossiah H. Cook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Marie Heeren		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-1963		17. INFORMANT ADDRESS Wife, Lorraine Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure, Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Liver failure, renal failure, ? cancer					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 22 Dec 1986 to 24 Dec 1986, that (I) (we) last saw the deceased alive on 19 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hart, Mary B. M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 24 Dec 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HART, MARY B.		22e. ADDRESS KACH, MED CLINIC, FT MEADE, MD 20755			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 30, 1986	23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Ch. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD	25a. DATE REC'D. BY REGISTRAR DEC 30 1986	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD			25b. REGISTRAR'S SIGNATURE via Gordon-Rodgers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove the burial papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other circumstance, the medical examiner will be notified of same.

0530 0530

026467 DEC-9

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 4 8 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Josephine — Coratolo			2a. DATE OF DEATH MONTH DAY YEAR 12/3/86			2b. HOUR 8:20 PM			
3 SEX Female		4 RACE Caucasian Italian		5. DATE OF BIRTH MONTH DAY YEAR 3 15 98		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b CITIZEN OF WHAT COUNTRY? Italy / U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10 CITY OR TOWN OF DEATH Crofton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Ctr.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE md		13b. COUNTY A.A.		13c. CITY OR TOWN Gambells		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2014 Hontela Dr. 21054	
14 FATHER'S NAME FIRST MIDDLE LAST Antonio N/A				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A Unk					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. N/A 579-62-5468		17. INFORMANT ADDRESS Elvina Charubas Same as 13 A-E			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Anoxia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
887 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Respiratory Arrest</u>	
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease / Uremia</u>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Senile Dementia, ASCVD, CHD, Cerebral State, Pernicious Anemia, Recent leg fracture

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>11/24</u> , 19 <u>86</u> , to <u>12/3/86</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>12/3/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Andrew Gordon MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Gordon				22e. ADDRESS 1657 Crofton Blvd Crofton Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/06/86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince George's Md	
24. FUNERAL DIRECTOR Lee Funeral Home, Inc. NAME ADDRESS Old Alexander Ferry Rd Clinton, Md 20735				25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE Julia Dearden-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: Item 21 is marked on item 18, the medical examiner's signature is required on item 21.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33482

FOR  
1. STATE  
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES P CREAMER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 09, 1986		2b. HOUR 440 AM								
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR August 24, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self employed		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland													
13b. COUNTY Anne Arundel		13c. CITY OR TOWN Ferndale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14 Third Avenue 21061							
14. FATHER'S NAME FIRST MIDDLE LAST John Creamer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Kraemer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-32-4339		17. INFORMANT ADDRESS Mrs. Helen Creamer 14 Third Avenue 21061							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks			
DUE TO, OR AS A CONSEQUENCE OF (b) HT										"			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ASCVD										year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Uremia, DM.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/25/86 to 12/9/86, that (I) (we) lost saw the deceased (above) (I) (we) (did not) view the body after death.													
22b. SIGNATURE David A. Schwartz, M.D.										22c. DATE SIGNED 12/9/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID A. SCHWARTZ, M.D.										22e. ADDRESS 7845 OAKWOOD RD, SUITE 200 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12/10/86		23c. NAME OF CEMETERY OR CREMATORY Balto.-Washington Cren.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Prince George Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Ambrose Funeral Home 1328 Sulphur Spring Road										25a. DATE REC'D. BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3348 33

05000 2 1100

Handwritten notes and calculations, including a table with columns labeled "DATE", "DESCRIPTION", and "AMOUNT". The text is mostly illegible due to fading and bleed-through.

DATE	DESCRIPTION	AMOUNT
1940	...	...
1941	...	...
1942	...	...
1943	...	...
1944	...	...
1945	...	...
1946	...	...
1947	...	...
1948	...	...
1949	...	...
1950	...	...



027089

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked as "yes", item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sylvester NMI Czeranek</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12-11-86</i>			2b. HOUR MIN <i>4:00 PM</i>	
3. SEX <i>m</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 26 08</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>78</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co. MD.</i>			
10. CITY OR TOWN OF DEATH <i>Galesville, Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Galesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Box 103 Bernway Rd, 21035 Galesville</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Crowner</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary E Gross</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT ADDRESS <i>Henrietta Stevenson-5644 Churcifton Rd, Churcifton, Md 20733</i>					
18. CAUSE OF DEATH (Enter only one cause per item 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction -</i> DUE TO, OR AS A CONSEQUENCE OF: Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>Yrs</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a:									
<i>Recently underwent Cardio-Thoracic Bypass graft</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>July 78 11 Dec 86</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the undersigned) attended the deceased from <i>July 78</i> to <i>11 Dec 86</i> , that (I) (last saw the deceased alive on <i>11 Dec 86</i> , and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.									
22b. SIGNATURE <i>Gary M. Richardson, MD.</i>				DEGREE <i>MD.</i>				22c. DATE SIGNED <i>12/12/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GARY M. RICHARDSON, MD.</i>				22e. ADDRESS <i>104 Forbes Street Annapolis, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/15/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ebenezer</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Galesville A.A. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>William Keeseison's Mortuary</i>				24b. ADDRESS <i>821 West St. Annapolis, Md. 21401</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 12 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>	

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Handwritten text in the lower section of the page, continuing the list or series of entries, possibly related to a survey or inventory.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT) <b>Richard Ray Culbertson</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>12 08 86</b>			2b. HOUR <b>1617</b>			
3. SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-23-1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TEXAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>						
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RANCHER-REACTOR</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>ANNE ARUNDEL</b> 13c. CITY OR TOWN <b>ANNAPOLIS</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>608 DARLAND HILLS DR 301</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM OLIVER CULBERTSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GLADYS L. McKINNEY</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) <b>1941-1943 522329646</b>		17. INFORMANT ADDRESS <b>RUTH B. CULBERTSON #13 21012</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD, Ventricular hypoxia,</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic Cardiomyopathy</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>COPD</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>86</b> , to <b>12/8</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12/6</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.												
22b. SIGNATURE <b>Robert Biern</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>12/9/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Biern</b>						22e. ADDRESS <b>51 Franklin St. Annapolis, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>12-12-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHELTENHAM VET.</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>CHELTENHAM P.G. MD.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel Annapolis MD</b>						25. DATE RECEIVED BY REGISTRAR <b>DEC 11 1986</b>		25. REGISTRAR'S SIGNATURE <b>James [Signature]</b>				

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME FIRST MIDDLE LAST FREDERICK N M N DAVIS Jr		DECEMBER 14, 1986		1055 M	
3 SEX M	4 RACE N	5 DATE OF BIRTH MONTH DAY YEAR 09 05 1907	6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10 CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Manor	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b COUNTY AA	13c CITY OR TOWN ANNAPOLIS	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST FREDERICK DAVIS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ORA BROWN		13e STREET ADDRESS / ZIP CODE 1991 REIDSVILLE STREET 21401	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 219 30 7752		17 INFORMANT ADDRESS Helen E. Hutton 1991 Reidville St ANNAPOLIS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HAEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) QUADREPLEGIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 4 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) BILATERAL BASAL PNEUMONIA					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 10-3-86 to 12/14/86, that (I) (we) lost saw the deceased alive on 12/14/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Harjit Singh MD		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/15/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) HARJIT SINGH M.D.		22e ADDRESS #8, 16th AVE. BALTIMORE, Md. - 21225			
23a BURIAL, CREMATION, REMOVAL (TYPE OF)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		12-19-1986		md national	
24 FUNERAL DIRECTOR NAME		23d LOCATION CITY OR TOWN COUNTY STATE		23e DATE REC'D BY REGISTRAR	
C. E. Hicks III		ANNAPOLIS		1922 Forest Drive	
25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
DEC 29 1986		Julia Davidson-Rudner			

MEDICAL CERTIFICATION

(77)

100-100-100

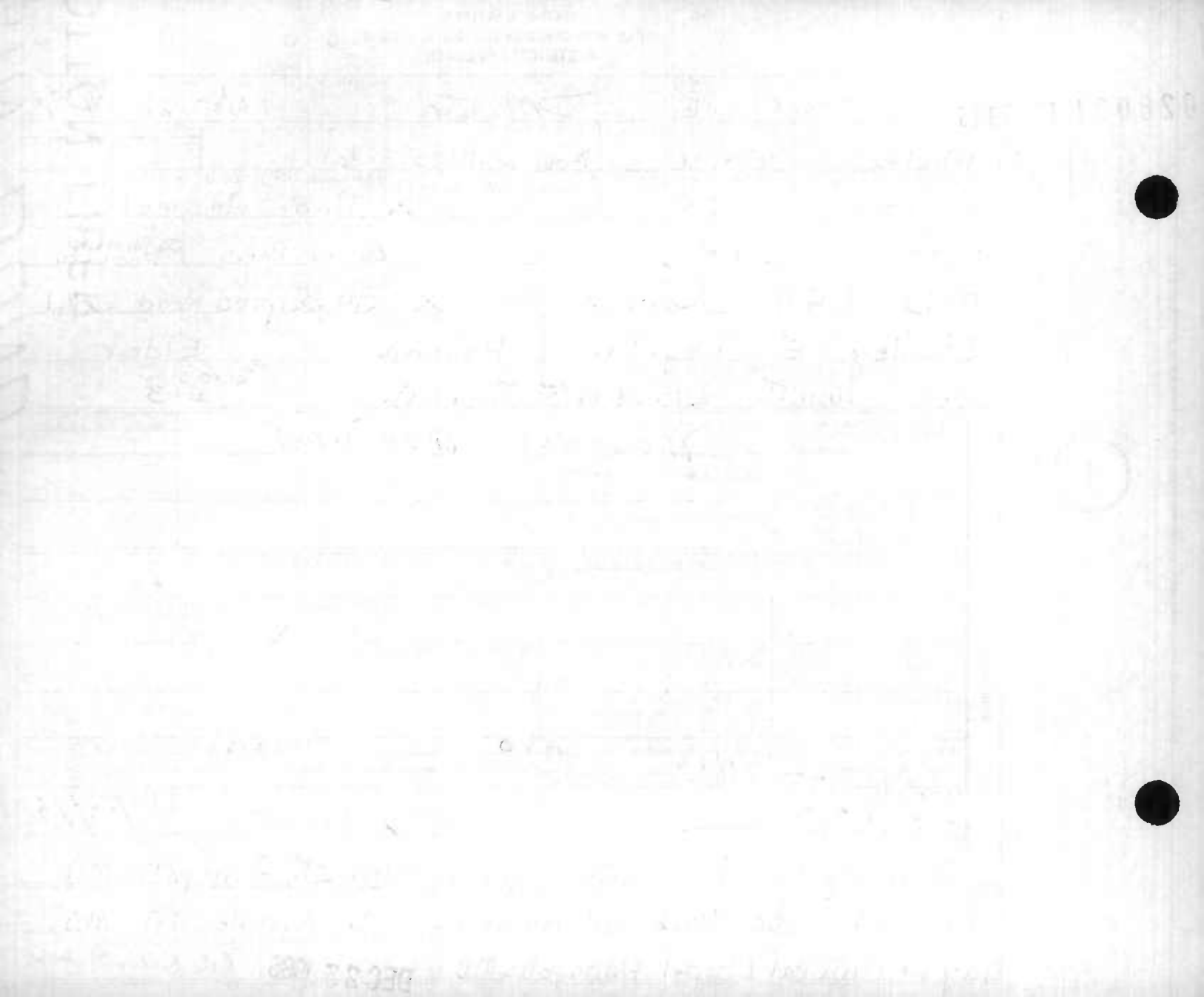
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 4 8 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STANLEY E. DAY, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 12/22/86		2b. HOUR 4:25 P.M.						
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 2, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
12. CITY OR TOWN OF DEATH Lothian		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 214 Bayard Road				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner- Pres.		15. KIND OF BUSINESS OR INDUSTRY Jewelry Pool Co.			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD			16b. COUNTY AA		16c. CITY OR TOWN Lothian		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 214 Bayard Road 20711		
17. FATHER'S NAME FIRST MIDDLE LAST Stanley E. Day, Sr.			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena Elder			19. ADDRESS Same as #13					
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR OR DATES) Yes WWII			21. SOCIAL SECURITY NO. 215-24-4475		22. INFORMANT John A. Day						
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
24. DATE OF OPERATION			25. CONDITION FOR WHICH OPERATION WAS PERFORMED			26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE						
34. I certify that (I) (this hospital) attended the deceased from 12/1/86, 1986, to 12/22/86, 1986, that (I) (we) last saw the deceased alive on 12/1/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.											
35. SIGNATURE Stanley P. Watkins MD					36. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			37. DATE SIGNED 12/22/86			
38. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley P. Watkins MD					39. ADDRESS 51 Franklin St., Annapolis, MD						
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			41. DATE Dec 27, 1986		42. NAME OF CEMETERY OR CREMATORY All Hallows		43. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD				
44. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD					45. ADDRESS		46. DATE REC'D. BY REGISTRAR		47. REGISTRAR'S SIGNATURE Julia Gordon-Rudack		



027831 DEC 23 86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 4 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ernest M. Death			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1986			2b. HOUR P 7:40 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wales		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 100 Rol Park			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool Designer		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse		
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Millersville			
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 100 Rol Park 21108					
14. FATHER'S NAME FIRST MIDDLE LAST Morgan Death				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Radcliff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 203 01 3706		17. INFORMANT ADDRESS Mrs. Betty (Wolfe) Death, (Same as 13a-e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lung disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/29, 1980, to 12/4, 1986, that (I) (we) lost saw the deceased alive on 12/4, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED 12/18/86	
22b. SIGNATURE Lorraine M. Dailey MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORRAINE M. DAILEY MD		22e. ADDRESS 8667 FT. SMALLWOOD RD. PASADENA, MD. 21122							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Secuirty Process, INC		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore MD			
24. FUNERAL DIRECTOR NAME McCully Funeral Homes		3204 Mountain Rd. Pasadena, MD 21122		25a. DATE REC'D. BY REGISTRAR DEC 19 1986		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 3 3 4 8 8  
CERTIFICATE OF DEATH

REG. NO.

ESR

1. DECEASED NAME (TYPE OR PRINT) <b>MOLLIE MARGARET DEGRAW</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 15, 1986</b>		2b. HOUR <b>102 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 6, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73 YRS.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD</b>
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A A Co.</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry BeSold</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura (Unknown)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No NA</b>		16b. SOCIAL SECURITY NO. <b>212.01.9573</b>		17. INFORMANT (Daughter) ADDRESS <b>Virginia E. Fitzhugh Same As 13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.				
22b. SIGNATURE <b>STEPHEN IZZI M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>7010 RITCHIE HIGHWAY GLEN BURNIE MARYLAND 21061</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Dec 18, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Memories</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Walker Town, Forsyth, N. C.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Singleton Funeral Home Glen Burnie, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 18 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, a voluntary injury, or another traumatic event, the medical examiner must be notified at once.

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THE UNIVERSITY OF CHICAGO

CHICAGO, ILL. 60607

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029461 JAN 1987

STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LIDA M. Delozier			2a. DATE OF DEATH MONTH DAY YEAR 12 27 86		2b. HOUR 11:50 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 29 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp		12a. USUAL OCCUPATION (IF OF WORKING AGE, GIVE USUAL OCCUPATION) Nursing Assistant Medical		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY A.A.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Joiner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina Savage		16. STREET ADDRESS / ZIP CODE 1620 Hilltop Rd. 21037	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-16-0105		17. INFORMANT Kenneth R. Sabel - Annapolis, MD 21401	

II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CVA

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) CAD - cardiovascular respiratory arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Jacob E. Teitelbaum	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/27/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Jacob E. Teitelbaum		139 Old Solomons Island Rd. Annapolis, MD	

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	23b. DATE Dec 30, 1986	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR JAN 5 1987	25b. REGISTRAR'S SIGNATURE Julia Swenson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please reinsert this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. The first step in the process of the development of a new product is the selection of a market. This is done by the marketing department of the company. The marketing department is responsible for the selection of a market, the development of a marketing plan, and the implementation of the marketing plan. The marketing department is also responsible for the selection of a distribution channel, the development of a distribution plan, and the implementation of the distribution plan.

2. The second step in the process of the development of a new product is the selection of a technology. This is done by the research and development department of the company. The research and development department is responsible for the selection of a technology, the development of a technology plan, and the implementation of the technology plan.

3. The third step in the process of the development of a new product is the selection of a manufacturing process. This is done by the manufacturing department of the company. The manufacturing department is responsible for the selection of a manufacturing process, the development of a manufacturing plan, and the implementation of the manufacturing plan.

4. The fourth step in the process of the development of a new product is the selection of a distribution channel. This is done by the marketing department of the company. The marketing department is responsible for the selection of a distribution channel, the development of a distribution plan, and the implementation of the distribution plan.

5. The fifth step in the process of the development of a new product is the selection of a sales force. This is done by the marketing department of the company. The marketing department is responsible for the selection of a sales force, the development of a sales plan, and the implementation of the sales plan.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 33490

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
Robert		Carl		DeSombre				12		26		19		86									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR							
Male	Cmn	Dec. 11, 1927		59 YRS.						12		26		19		86							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Philadelphia, PA		USA						AA															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Glen Burnie		North Annapolis		Engineer		Bendix																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Md.		AA		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		711 Delmar Ave															
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
Hugo DeSombre				Emma Hage1																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
Yes				Korea				178-22-1745				Agnes M. DeSombre, Same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) <u>A.I.S.C.U.D.</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED															
William P. Jones, M.D.				Deputy				12/26/86															
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
William P. Jones, M.D.				695 America Crt. Davidsonville, Md 21035																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Cremation				Dec. 30, 86				Security Process, Inc.				Catonsville Baltimore MD											
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE							
James S. Kirkley, Glen Burnie, MD								DEC 30 1986								Julia Davidson							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PW 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

86 33491

FOR  
STATE  
REGISTRAR

1- DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Joseph R. Didion

2a. DATE KNOWN OF DEATH  
ESTIMATED  
MONTH DAY YEAR  
12-6 1986

2b HOUR

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Sept 24, 1908

6. AGE (IN YEARS)

78

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD  
MONTH DAY YEAR  
12-6 1986

2d HOUR

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel

MD

10. CITY OR TOWN OF DEATH

Lothian

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

104 4th St, Waysons Court

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Carpenter/Self-employed

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

Anne Arundel

13b. CITY OR TOWN

Lothian

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

104 4th Street

Waysons Court

14. FATHER'S NAME

Philip

MIDDLE

LAST

Didion

15. MOTHER'S MAIDEN NAME

Ida

MIDDLE

LAST

Mag Spiegel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16b. SOCIAL SECURITY NO.

202-12-8714

17. INFORMANT

David Didion/Cheverly, MD 20785

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL  
SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE

SIGNED 12-6-86

EXAMINER'S NAME  
(TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct, Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

Dec 9, 1986

23c. NAME OF CEMETERY OR CREMATORY

Queen of Heaven

23d. LOCATION

Peters Township, Penn.

COUNTY

STATE

24. FUNERAL DIRECTOR

Harold Connell & Son, Inc.  
5120 W. Library Ave, Bethel Park, Penn.

25a. DATE REC'D BY REGISTRAR

DEC 12 1986

25b. REGISTRAR'S SIGNATURE

Julia Tindon-Randall

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.3. WHEN PAGE 5 IS FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



028847 JAN -2 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

33492

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doris L Doenges			2a. DATE OF DEATH MONTH DAY YEAR 12 22 86		2b. HOUR 9 A M
3. SEX female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 20 27		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen Hosp Homemaker		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY A.A.Co.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Md. 21401 1210 Southview Dr. Annapolis	
14. FATHER'S NAME FIRST MIDDLE LAST Russell F. Watts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy E. Phillips			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-22-1865		17. INFORMANT ADDRESS Annapolis, Md. 21401 Judith Krzyzaniak, 405 Master Derby Ct	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1985 19, to 12/22/86 19, that (I) (we) last saw the deceased alive on 12/22/86 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE S. WATKINS		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/23/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. WATKINS		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/26/86	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemt.	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A.Co. Md.
24. FUNERAL DIRECTOR NAME McCuilly Funeral Home, 130 E. Fort Ave.		25a. DATE REC'D. BY REGISTRAR DEC 30 1986	
25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please submit the completed papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

1950-1-10

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DEC 30 1949

026868 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 33493			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICK R. DOWSETT				2a. DATE OF DEATH MONTH DAY YEAR DEC 5 86			
3. SEX MALE				2b. HOUR P.M.			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 13 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IN CASE OF FACILITY, GIVE STREET ADDRESS) ADGEN Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COL. USMC		12b. KIND OF BUSINESS OR INDUSTRY Military	
13a. STATE MD.		13b. COUNTY ANNA		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE C. DOWSETT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY POWER		13e. STREET ADDRESS / ZIP CODE 731 WARREN DR. 21403			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. WWTI-KOREA 215 38 7575		17. INFORMANT ADDRESS MARGARET MOSS DOWSETT #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) oat cell CA of lung DUE TO, OR AS A CONSEQUENCE OF (b) cigarette use Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COPD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 9 1982, to December 5 1986, that (I) (we) last saw the deceased alive on December 5 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stuart E. Selonick, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.				22e. ADDRESS 51 Franklin St. Annapolis, Md. 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/7/86		23c. NAME OF CEMETERY OR CREMATORY CEDAR Hill		23d. LOCATION CITY OR TOWN COUNTY Baltimore P.G. MD.	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel				24b. ADDRESS Annapolis, MD		25a. DATE REC'D. BY REGISTRAR DEC 11 1986	
25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send page 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	33494		
1. DECEASED NAME (TYPE OR PRINT) Agnes Martha Duval										2a. DATE OF DEATH MONTH DAY YEAR December 22, 1986		2b. HOUR 10 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 15, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.							
10. CITY OR TOWN OF DEATH Severn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1403 Illinois Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Operator		12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1403 Illinois Ave. 21144					
14. FATHER'S NAME FIRST MIDDLE LAST George Raivel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances u/k									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-12-9283		17. INFORMANT ADDRESS Agnes Fant Same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs. yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Schmidlein MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12 22 86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Schmidlein				22e. ADDRESS Doctors care Severn Pk. MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 24 Dec. 86		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD							
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie MD 21061				25a. DATE REC'D. BY REGISTRAR DEC 23 1986		25b. REGISTRAR'S SIGNATURE A. J. Anderson-Pendley							

BP

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and" and "the" are faintly visible.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

028090 DEC 1986

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES Erick Edberg</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec. 20, 1986</b>			2b. HOUR M <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 30, 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>99</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>Sweden</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1100 Hoover St.</b>				12a. USUAL OCCUPATION (IF OF WORK IN MOST OF WORKING LIFE) <b>SEA CAPTAIN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private Industry</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1100 Hoover St. 21403</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Matilda UNK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE IN FULL) <b>262-22-1534</b>		17. INFORMANT NAME <b>Myrtie K. Edberg</b>		ADDRESS <b># 13</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Asc. A**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Ser. Ith**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **1985** to **1986**, that (I) (we) lost  
saw the deceased alive on **1985**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☒

MEDICAL  
DIRECTOR ☐

STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

**12/20**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**Robert Biern**

**51 Franklin St. Annapolis, MD.**

23a. BURIAL, CREMATION, REMOVAL  
(CHECK ONE)  
**BURIAL**

23b. DATE  
**12/22/86**

23c. NAME OF CEMETERY OR CREMATORY  
**MD. Veterans Cemetery**

23d. LOCATION  
CITY OR TOWN  
**Crownsville**

COUNTY  
**A.A.**

STATE  
**MD.**

24. FUNERAL DIRECTOR  
NAME

ADDRESS

**Taylor Funeral Chapel Annapolis, MD.**

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

**DEC 23 1986**

**John Francis [Signature]**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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28225 DEC 29 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR ☐ HOUR  
ESTIMATED ☐ 12 18 861. DECEASED NAME  
(TYPE OR PRINT)FIRST  
DIANEMIDDLE  
CHASTAINLAST  
ELLENSON3. SEX  
Female4. RACE  
White5. DATE OF BIRTH  
MONTH DAY YEAR  
May 8, 19326. AGE (IN YEARS)  
LAST BIRTHDAY  
54 YRS.IF UNDER 1 YR.  
MONTHS DAYSIF UNDER 24 HRS.  
HOURS MIN.2c. DATE PRONOUNCED DEAD  
MONTH DAY YEAR HOUR  
12 18 86 0157

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Kansas

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel

10. CITY OR TOWN OF DEATH

Glen Burnie

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

North Arundel

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Self Employed

12b. KIND OF BUSINESS OR INDUSTRY

Art Studio

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland13b. COUNTY  
Anne Arundel13c. CITY OR TOWN  
Gibson Island13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒13e. STREET ADDRESS  
Box 321 Broadwater Way

14. FATHER'S NAME

FIRST MIDDLE LAST  
Hartley

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Pauline

Nelson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

N/A

16b. SOCIAL SECURITY NO.

544-40-5506

17. INFORMANT

(Son)

ADDRESS

3085 Gertrude

Mr. Robert C. Ellenson Riverside, CA92506

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

8199  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cardiac Arrest.

Chest Trauma.

Motor Vehicle Accident.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL

SIGNATURE

William P. Jones, M.D.

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE

SIGNED

12-18-86

EXAMINER'S NAME

(TYPE OR PRINT)

William P. Jones, M.D.

ADDRESS

695 America Crt. Davidsonville, Md 21035

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)  
Cremation

23b. DATE

Dec 19, 1986

23c. NAME OF CEMETERY OR CREMATORY

Security Process, Inc.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Catonsville, Baltimore, Md.

24. FUNERAL DIRECTOR

NAME

H. Harry Hobbs

ADDRESS

Singleton Funeral Home Glen Burnie, Md. 21061

25a. DATE REC'D BY REGISTRAR

DEC 23 1986

25b. REGISTRAR'S SIGNATURE

[Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

ONE

THREE

2000 03308



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please follow the instructions on page 1 of the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRENE KENNEDY ELLIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec 30 1986</b>			2b. HOUR AM PM <b>A</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 6 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>FLORIDA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANN ARUNDEL</b> MD.				
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A.A. GEN HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>21012 SER.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RET. GOV</b>		
13a. STATE <b>MD.</b>			13b. COUNTY <b>HH. CO.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK JOSEPH KENNEDY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY ANNIE BARNOTT</b>			16. STREET ADDRESS / ZIP CODE <b>1919 BLUE EDGE DR 21401</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214289108</b>		17. INFORMANT <b>ERNEST M. ELLIS</b>		17. ADDRESS <b># 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Reflexly anast</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>6 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 30 1986</b> to <b>Dec 30 1986</b> , that (I) (we) last saw the deceased alive on <b>Dec 30 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Genard Blumel</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>12/31/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GENARD CHAPPEL</b>			22e. ADDRESS <b>8 EMBLETON DR SEVENTH PARK MD 21146</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/3/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Margaret's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Margaret's ANN MD.</b>			
24. FUNERAL DIRECTOR NAME <b>TAYLOR FUNERAL CHAPEL</b>			ADDRESS <b>ANNAPOLIS MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John P. Anderson-Randall</b>		

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029533 JAN 5 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove container pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MARGUERITE L. ENGWER</b>					2a. DATE OF DEATH MONTH <b>12</b> DAY <b>30</b> YEAR <b>86</b>			2b. HOUR <b>2:55</b> AM			
3 SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>December</b> DAY <b>18</b> YEAR <b>1897</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.					
10 CITY OR TOWN OF DEATH <b>Crofton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1640 Dryden Way</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Crofton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1640 Dryden Way 21114</b>	
14. FATHER'S NAME FIRST <b>Wesley</b> MIDDLE <b></b> LAST <b>Fredenburgh</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Julia</b> MIDDLE <b></b> LAST <b>Pulver</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b SOCIAL SECURITY NO. <b>106-10-2105</b>		17 INFORMANT ADDRESS <b>Dorothy L. McDowell 1640 Dryden Way Crofton, MD 21114</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Breast Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/9/86</b> to <b>12/30/86</b> , that (I) (we) last saw the deceased alive on <b>12/10/86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E W Cole</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/30/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E W COLE</b>				22e. ADDRESS <b>51 FRANKLIN ANNAPOLIS MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal/Burial</b>				23b. DATE <b>JAN 3, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Town of Catskill Cem.</b>		23d. LOCATION CITY OR TOWN <b>Catskill</b> COUNTY <b>Greene</b> STATE <b>New York</b>			
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>				16000 Annapolis Road Bowie, MD 20715-3043				25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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027157 DEC 15 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE WITT LAST EVANS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 10, 1986			2b. HOUR AM 0012 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 15 25		6. AGE (IN YEARS LAST BIRTHDAY) 61		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NORTH ARUNDEL HOSPITAL)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST George MIDDLE WITT LAST			15. MOTHER'S MAIDEN NAME FIRST Edna MIDDLE FRANKENBERRY LAST			16. STREET ADDRESS / ZIP CODE 328 S. Oldham Street 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-16-3900		17. INFORMANT Wm. H. Evans				ADDRESS 1905 Arundel Rd. Pasadena 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG (Bronchogenic) Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK NA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> 19 <u>86</u> , to <u>12/10</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE DR WILLIAM SCHLOTT				DEGREE ATTENDING PHYSICIAN				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS BALTIMORE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-13-86		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Westview, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave.				25a. DATE REC'D. BY REGISTRAR DEC 12 1986		25b. REGISTRAR'S SIGNATURE Julia Darden-Randall			

RECEIVED 10, 1966 11:11 AM

FROM: [illegible]  
TO: [illegible]  
SUBJECT: [illegible]

DATE: 10/11/66  
TIME: 11:11 AM



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IN WILKINSON COUNTY, GA  
THOMAS H. HARRIS, JR.

1-1-67  
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029458 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LORENA Strohm Evans</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12/26/86</b>		2b. HOUR <b>4:30</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 10, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AA Co School Teacher</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John C. Strohm</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alma A. Kruger</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-369282</b>		17. INFORMANT ADDRESS <b>Allan Paul Evans - Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cause of Cray</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/86</b> , 19____, to <b>12/26/86</b> , 19____, that (I) (we) last saw the deceased alive on <b>12/26/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Stanley R. Watkins</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/26/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stanley R. Watkins, M.D.</b>				22e. ADDRESS <b>51 Franklin St. Annapolis, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 30, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury United Meth.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arnold AA MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Tidson-Roads</b>	

BP



025978 DEC

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) IDA MAE FINNEGAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 01, 1986			2b. HOUR 6.17 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 6, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3302 West Belvedere Ave. Balto 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence M. Wheeler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Mielke							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 16 5342		17. INFORMANT Hampstead Md. 21074 Bonnie Shipley 4417 DaveRill Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Wound - sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>① Asepsis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/23/86</u> , 19 <u>86</u> , to <u>12/1</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Elmo M. Gayoso</u>						DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/1/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELMO M. GAYOSO, M.D.						22e. ADDRESS 273-F PENINSULA FARM ROAD ARNOLD, MARYLAND, 21012				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/3/86			23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Pk			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME George J. Gonca 4001 Ritchie Hgwy Balto. Md.						25a. DATE RECEIVED BY REGISTRAR DEC 2 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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DECEMBER 01 1986 0:17 AM

PLAZA

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AND ARUNDEL COUNTY

NORTH ARUNDEL HOSPITAL

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11/11/86

275-F HUNTINGDALE FARM ROAD

ARUNDEL, MARYLAND 21013

EDWARD M. GORD, M.D.

026747 DEC 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE AND PRINT) MARY ELIZABETH FURMAN			2a. DATE OF DEATH MONTH DAY YEAR 12-07-86			2b. HOUR 0430 M			
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 08-05-19		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) G.A.G. Hospital				12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1140 Madison St. 21403	
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14. FATHER'S NAME FIRST MIDDLE LAST Robert R. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche E. Davis			
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Blanche Garrett - 380 Parkington Ave, Balto, Md.	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 70 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> 70 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Squamous Cell Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 1 Dec, 1986, to 7 Dec, 1986, that (I/we) last saw the deceased alive on 7 Dec, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Don Blouie MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7 Dec 86</u>	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don Blouie</u>		22e. ADDRESS			
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/12/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Annapolis A.A. Md.</u>	
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24. FUNERAL DIRECTOR NAME <u>William Keese + Sons, Monticary - 821 West St.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 10 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and an autopsy will be required.

MEDICAL CERTIFICATION

BP

Received

625 10/1/11

10/1/11

10/1/11



10/1/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	6	3	3	5	0	3
1. FOR STATE REGISTRAR										CERTIFICATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH MONTH DAY YEAR						
LILLITH GREYTON GARDNER										DECEMBER 28, 1986						
3. SEX Female										2b. HOUR 0755 AM						
4. RACE White										6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.						
5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1919										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Anne Arundel Co.										9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.						
7b. CITIZEN OF WHAT COUNTRY? USA										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist.						
10. CITY OR TOWN OF DEATH GLEN BURNIE										12b. KIND OF BUSINESS OR INDUSTRY Funeral Home						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL										13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13a. STATE Maryland										13b. STREET ADDRESS / ZIP CODE 402 O Street, S. E. 21061						
13c. COUNTY AA										13d. CITY OR TOWN Glen Burnie						
14. FATHER'S NAME FIRST MIDDLE LAST Richard Martin										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillith Dicus						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 217-62-8090						
17. INFORMANT ADDRESS Kenneth B. Gardner, Same as 13																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cardiovascular Disease</u>																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a																
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						
21f. LOCATION STREET CITY OR TOWN COUNTY STATE																
22a. I certify that (I) (this hospital) attended the deceased from 19 85, to 12, 19 86, that (I) (we) last saw the deceased alive on OCT 6, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																
22b. SIGNATURE DEGREE										22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN F. ROBBINS, M.D.										22e. ADDRESS 1404 CRAIN HIGHWAY GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Dec. 31, 1986						
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park										23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD						
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD										25a. DATE REC'D. BY REGISTRAR DEC 30 1986						
										25b. REGISTRAR'S SIGNATURE Julia Benson-Roads						

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AMERICAN CIVIL

UNITED STATES DEPARTMENT OF JUSTICE



UNITED STATES DEPARTMENT OF JUSTICE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John J. Gibbons, Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 18 86</b>			2b. HOUR <b>1620</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 8 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PROFESSOR PENNSYLVANIA</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE UNIVERSITY</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE <b>1623 ST. MARGARETS ROAD 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN J. GIBBONS Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>161-26-3703</b>		17. INFORMANT ADDRESS <b>JAY GIBBONS SAME AS 13E</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>from negative sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>from wound</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>severe brainstem stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>previous CVA, HASAD</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>12/18/86</b> to <b>12/18/86</b> . I saw the deceased alive on <b>12/18/86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Anthony J. Lapenta</b>				22c. DATE SIGNED <b>12/18/86</b>				22d. SIGNATURE <b>Anthony J. Lapenta</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12 22 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CENTRE CO. MEMORIAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>STATE COLLEGE CENTRE PENN.</b>			
24. FUNERAL DIRECTOR NAME <b>KOCH FUNERAL HOME</b>		25a. DATE RECEIVED BY REGISTRAR <b>DEC 24 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Ross</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

*[Faint, illegible handwritten text and markings covering the page]*

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DEC-8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 and 6 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND										
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR <b>Dorothy C. Gibson</b>					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy C. Gibson</b>					2a. DATE OF DEATH MONTH <b>12</b> DAY <b>1</b> YEAR <b>86</b>					2b. HOUR <b>10</b> MIN <b>45</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>08</b> DAY <b>08</b> YEAR <b>17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7b. UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Nursing &amp; CC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Register Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>A.A.Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>230C Woodhill Dr. 21061</b>	
14. FATHER'S NAME FIRST <b>Howard</b> MIDDLE <b>A.</b> LAST <b>Carrick</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Ballantine</b> LAST <b>Ballantine</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>213 32 5095</b>		17. INFORMANT <b>Glen Burnie Md. 21061</b> <b>Frank L. Gibson 230 C Woodhill Dr.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>arteriosclerosis</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3-8</b> , 19 <b>85</b> , to <b>12-1</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11-13</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Mustafa C. O. 2 MD</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>12-1-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mustafa C. O. 2 MD</b>					22e. ADDRESS <b>605 B-A Blvd SP Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/4/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Balto. Md. 21225</b> <b>George J. Gonce 4001 Ritchie Hgwy</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1986</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove continuation pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mary N Gogats			2a. DATE OF DEATH MONTH DAY YEAR Dec 7 1986		2b. HOUR 8:06P <sub>M</sub>	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 7, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Clifton, N. J.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Ft. Meade	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY AA	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 409 Morningside Drive 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Sabot			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Vovchik			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 097-16-5768		17. INFORMANT ADDRESS John C. Gogats, Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcal Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 24 hours 48 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6 Dec</u> 19 <u>86</u> to <u>7 Dec</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7 Dec</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Carl P. Stamm</u> MD				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL P. STAMM
22e. ADDRESS Kimbrough Hospital				22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 12, 86		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR DEC 9 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Deaton-Randall</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Matthew Christopher Galeski</b>									
2a. DATE OF DEATH MONTH <b>12</b> DAY <b>20</b> YEAR <b>86</b> 2b. HOUR <b>3:40</b> PM									
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>19</b> YEAR <b>86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS <b>24</b> DAYS <b>14</b> HOURS <b>14</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Pasadena, Md. 7914 Kings Bench Pl. 21122</b>	
14. FATHER'S NAME FIRST <b>Raymond</b> MIDDLE <b>James</b> LAST <b>Galeski, Jr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Maurcen</b> MIDDLE <b>----</b> LAST <b>O'Donnell</b>				ADDRESS <b>Linthicum, Md. 623 Groveland Rd.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>21090 Mr. Raymond Galeski, Sr.</b>		ADDRESS <b>623 Groveland Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Septic shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac anomaly?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>F. Aliabadi</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>21/403</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FARHAD ALIABADI</b>				22e. ADDRESS <b>2016 Quay Village Ct Annapolis 21403</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/23/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemt.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore City</b> COUNTY <b>Md.</b> STATE			
24. FUNERAL DIRECTOR NAME <b>Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 23 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Charles M. Gray								12 23 86									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	Can	12 26 59		26 YRS.						12 23 86						19 25	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
BALTIMORE, MARYLAND		U.S.A.		WIDOWED		DIVORCED		FA. ARUNDEL CO.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY											
Annapolis		ANNE ARUNDEL GEN		DISEL MECHANIC													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		AA		Edgewater		YES <input type="checkbox"/> NO <input type="checkbox"/>		222 MARYLAND AVE. 21037									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
CHARLES		LUCY H. CRISMOND		YES		216-74-4555		DAWN MARIE GRAY		SAME AS 13E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
PART I DEATH WAS CAUSED BY:				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
IMMEDIATE CAUSE (a)																	
8199 Head & Neck Trauma																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) Motor Vehicle Accident																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
William P. Jones M.D.		Deputy		12/23/86													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
William P. Jones, M.D.		695 America Crt. Davidsonville, Md. 21035															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		12-27-86		HILLCREST ANNAPOLIS		ANNE ARUNDEL CO. MARYLAND											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS, MD		JAN 8 1987		Julia Beaton-Randall													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 of 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18, state any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 0 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ISAAC GREEN SR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 23, 1986</b>			2b. HOUR <b>950 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/15/11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>AA</b>		13c. CITY OF TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Garrison Green Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Brown</b>				13e. STREET ADDRESS / ZIP CODE <b>8123 Hogneck Rd. Pasadena 21122</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Mary Spencer 335 Addison Dr. Glen Burnie 21061</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rhabdomyolysis</b> <b>Septicemia with metabolic acidosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Urosepsis</b> <b>Pneumonia fulminans</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Arteriosclerotic cardio-vascular disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>—</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>— — — — —</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 15, 1986</b> to <b>Dec. 23, 1986</b> , that (I) (we) last saw the deceased alive on <b>Dec. 23, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED <b>12-23-86</b>	
22b. SIGNATURE <b>Benjamin de Guzman</b> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BENJAMIN A. DE GUZMAN, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. ADDRESS <b>325 HOSPITAL DRIVE SUITE 108 GLEN BURNIE, MARYLAND 21061</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/27/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Magothy A.A. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Chas.A.Rice FSPA 1300 Eutaw Place</b>	
25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1986</b>				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

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Handwritten notes and signatures, including "AIA" and "L. J. ...".

DEC 30 1998

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET M GREENFIELD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 18, 1986</b>		2b. HOUR <b>549 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 10, 1900</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>						
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>MD</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Edgewater</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Will E. Durity</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Langley</b>		13d. STREET ADDRESS / ZIP CODE <b>235 Oakwood Rd. Edgewater Md. 21037</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO N/A</b>		16b. SOCIAL SECURITY NO. <b>5 77-22-7712</b>		17. INFORMANT ADDRESS <b>William C. Covington Same as 13 A-E</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory and cardiac failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>gangrene of right small bowel</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe Metabolic acidosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Septis, Renal Failure</b>						
19a. DATE OF OPERATION <b>12-13-86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute abdomen</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12-13-86</b> to <b>12-18-86</b> , that (I) (we) last saw the deceased alive on <b>12-17-86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death <b>86</b>						
22b. SIGNATURE <b>U. R. Sunkara M</b>		DEGREE <b>M</b>		22c. DATE SIGNED <b>12-18-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>U. RAO SUNKARA, M.D.</b>		22e. ADDRESS <b>3001 S. HANOVER STREET, SUITE 210 BALTIMORE, MARYLAND 21230</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/20/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Natl. Cem</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Prince George's Md</b>		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b>		24b. ADDRESS <b>Old Alexander Ferry Rd. Clinton, Md 20735</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 29 1986</b>		
25b. REGISTRAR'S SIGNATURE <b>Julia Henderson-Baker</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.

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DECEMBER 18, 1950 2:40 PM

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NORTH ARNOLD HOSPITAL

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201 S. HANOVER STREET, SUITE 210  
BALTIMORE, MARYLAND 21201

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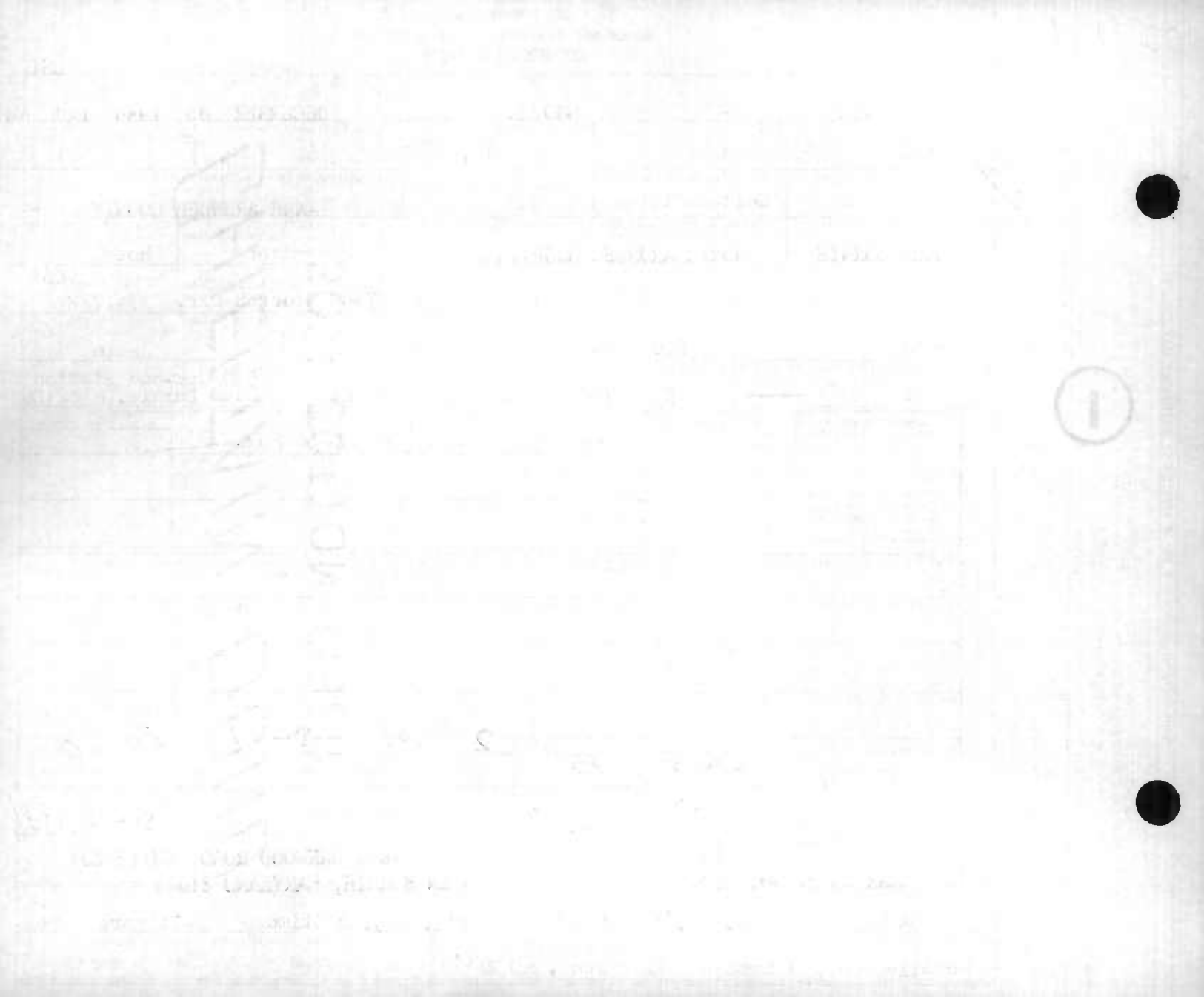
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be evaluated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 3 3 5 1 1  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE - GROVER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 06 1986		2b. HOUR 140 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 12, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY House
13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST John Bzuchacz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marianna Jakin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 215 22 7844		17. INFORMANT ADDRESS Cleveland Knight 519 Oakwood Station RT Glen Burnie, MD 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 2</u> 19 <u>86</u> , to <u>Dec. 6</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec. 5</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Dec. 6, 1986</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WIL, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 12, '86		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l. Cem.	
24. FUNERAL DIRECTOR NAME McCully Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 12 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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FOR  
STATES  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

3 3 5 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SARAH E. GROSS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 17 86</b>			2b. HOUR M <b>M</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 14 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNAPOLIS CONVALESCENT CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>608 Monterey Avenue 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN SELLMAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY E. PETERS</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Annapolis, Md. 21401</b> <b>NAOMI BRYANT 608 Monterey Ave.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> WHILE AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> 19 <b>86</b> , to <b>12/17</b> 19 <b>86</b> , that (I) (we) lost above (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <b>Debra M. Brown</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/18/86</b>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12-20-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. MARYLAND</b>			
24. FUNERAL DIRECTOR <b>WILLIAM REESE &amp; SONS TUNNEY, P.A.</b>			25a. DATE RECD. BY REGISTRAR <b>DEC 18 1986</b>			25b. REGISTRAR'S SIGNATURE <b>John S. Benson</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this page. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33513

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Roy A. Hall</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec. 8. 1986</b>		2b. HOUR <b>12:30pm</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>31 07 79</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Annapolis Nursing, Conv. Cen.</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR NATURE OF WORKING LIFE) <b>Salesman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Ind.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1295 Cape St. Claire Rd. 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jesse O. Hall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennette Cordelia Stewart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>233-01-0344</b>		17. INFORMANT ADDRESS <b>Beverly Bond. # 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Malignant Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 27<sup>th</sup> 1985</b> , to <b>Dec. 8 1986</b> , that (I) (we) last saw the deceased alive on <b>Dec 7, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stuart E. Selonick, M.D.</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/8/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STUART E. SELONICK, M.D.</b>		22e. ADDRESS <b>51 Franklin St. Annapolis, Md. 21401</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12-11-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wheeling West Va.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>T.A. Hardesty Annapolis, Md. 21401</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 12 1986</b>	25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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028223 DEC 20 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33514

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) IRVING WOODBERRY HARDY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 17 1986		2b. HOUR 3 45 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 8, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (Ret.) (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Machanic		12b. KIND OF BUSINESS OR INDUSTRY Civil Service		
13a. STATE Maryland			13b. COUNTY A A Co.		13c. CITY OR TOWN Millersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Irving M. Hardy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie M. Forney		13e. STREET ADDRESS / ZIP CODE 21108 104 Rol-Park Trailer Court			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT (Wife) ADDRESS Mrs. Florence L. Hardy		Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GI Bleeding</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-2-86</u> to <u>12-17-86</u> , that (I) (we) lost saw the deceased alive on <u>12-16-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Chakmakian</u>		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-18-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKMAKIAN V. CYRIAC, M.D.		22e. ADDRESS 14 WELLHAM AVENUE, SUITE 101 GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Md.		
24. FUNERAL DIRECTOR NAME R. H. Haskins				25a. DATE REC'D. BY REGISTRAR DEC 23 1986		25b. REGISTRAR'S SIGNATURE <u>John William Pugh</u>		
24. FUNERAL HOME Singleton Funeral Home Glen Burnie, Maryland								

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BB 33214

188221

188221



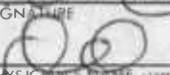
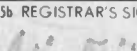
188221

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33515

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR	
Hilda Beatrice Harman				December 30, 1986		11:20 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		December 3, 1905		81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				ANNE ARUNDEL CO MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		106 S. Broadview Blvd.		Homemaker		Own Home	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				A A Co.		Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Harry E. Norris				Rosa Berryman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (Son) ADDRESS		409 Melrose Ave. Glen Burnie, Md. 21061	
No		NA		Ronald E. Harman			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe CHF DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/1/81 to 12/30/86, that (I) (we) last saw the deceased alive on 12/19/86, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE 		22c. DATE SIGNED 12/31/86		22d. PHYSICIAN'S TITLE (TYPE OR PRINT) Dr. David A. Schwartz, M.D.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 6 1987		25b. REGISTRAR'S SIGNATURE 	

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RECEIVED 20X20107X002

Handwritten notes and signatures, including a large signature at the bottom.

026499 DEC-9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with (72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or any traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 33516  
EST

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH AUDREY HARPER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 04, 1986		2b. HOUR 649 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2/24/1923		
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife.		12b. KIND OF BUSINESS OR INDUSTRY Domestic		13a. STREET ADDRESS / ZIP CODE 406 Milton Ave., 21061		
13a. STATE Maryland		13b. COUNTY A.A. Co.,		13c. CITY OR TOWN Glen Burnie		
14. FATHER'S NAME FIRST MIDDLE LAST Ernest William Burck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Helen Rodey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 189 12 6724		17. INFORMANT ADDRESS W Harry E. Harper Balto. Md. 21227		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ischemic cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>9 years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) this hospital attended the deceased from <u>JULY</u> , 19 <u>86</u> , to <u>12/4/</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>November 26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Marc Okun MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC OKUN, M. D.		22e. ADDRESS 615 HAMMONDS LANE BALTIMORE, MARYLAND 21225				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk		
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA Co. Md.		24. FUNERAL DIRECTOR 237 E. Patapsco Ave. McCully Funeral Homes Balto. Md. 21225				
25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Rudner</u>				

BP

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
PLANT INDUSTRY  
WASHINGTON, D. C.

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PLANT INDUSTRY  
WASHINGTON, D. C.

028215 DEC 19 86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33517

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA ELIZABETH HASLUP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 17, 1986</b>		2b. HOUR <b>700 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>October 2, 1915</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>71 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>A A Co.</b> 13c. CITY OR TOWN <b>Pasadena</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ferdinian Reuwer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Muehlhan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No NA</b>		16b. SOCIAL SECURITY NO. <b>217.72.7372</b>		17. INFORMANT (Husband) ADDRESS <b>Mr. William C. Haslup Same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest, ventricular tachycardia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Congestive Heart Failure</b>					<b>4 years</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Old Myocardial Infarction</b>					<b>4 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Diabetes Mellitus, Chronic obstructive lung disease.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>11/30</b> , 19 <b>86</b> , to <b>12/17</b> , 19 <b>86</b> , that (1) we last saw the deceased alive on <b>12/17</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we did (did not) view the body after death.					
22b. SIGNATURE <b>Marc Okun, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/11/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC OKUN, M.D.</b>		22e. ADDRESS <b>615 HAMMONDS LANE BALTIMORE MD, 21225</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 22, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Vet. Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville A A Co. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>J. H. Hopkins</b> ADDRESS <b>Singleton Funeral Home Glen Burnie, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 23 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Rudek</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked on item 18 above only injury, or other traumatic event, the medical examiner must be notified.

BP

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BOOK C-110M-1035-1

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ADDITIONAL DATA

ADDITIONAL DATA

ADDITIONAL DATA

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ADDITIONAL DATA

ADDITIONAL DATA

ADDITIONAL DATA

028171 DEC 29

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

John Stevenson

Haught, M.D.

2a. DATE KNOWN OF DEATH

MONTH DAY YEAR

12 5 1986

2b. HOUR

M

3. SEX

M

4. RACE

CAU

5. DATE OF BIRTH

MONTH DAY YEAR

7 25 1967

6. AGE (IN YEARS)

LAST BIRTHDAY YRS.

67

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

12 5 1986

2d. HOUR

2039

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

West Virginia

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel

MD.

10. CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Anne Arundel Gen

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Self Employed

12b. KIND OF BUSINESS OR INDUSTRY

Physician

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

AA.

13c. CITY OR TOWN

West River

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

4920 W. Chalk Point

20778

14. FATHER'S NAME

FIRST

O.

MIDDLE

Lloyd

LAST

Haught

15. MOTHER'S MAIDEN NAME

FIRST

Myrta

MIDDLE

LAST

Stevenson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

WW 2

17. INFORMANT

236-20-5486

17. INFORMANT ADDRESS

Mrs. Elizabeth B. Haught, Same as Line 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

Cardiac Arrest

(b) Severe A.S.C.U.D.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

William P. Jones, MD

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

12-6-86

EXAMINER'S NAME (TYPE OR PRINT)

William P. Jones, MD

ADDRESS

695 America Ct. 21035

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-09-86

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d. LOCATION

Brentwood, P.G., Maryland

COUNTY

STATE

24. FUNERAL DIRECTOR

FRANCIS GASCH'S SONS FUNERAL HOME, P.A.

4739 Baltimore Ave., Hyattsville, Maryland

25a. DATE REC'D. BY REGISTRAR

DEC 23 1986

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Rodriguez

DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXCLUDED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
LOUISE		HAWKINS		DEC. 10, 1986			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
female		white		March 16, 1902		84	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Penn.		U.S.A.				Anne Arundel Co.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Ann. nursing & Conv. Center		salesclerk		G.C.Murphy	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		A.A. Co.		Gambrills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE			
Edgar		Perry		1073 Snow Hill lane			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS	
no		218-20-0191		Carlyle Hawkins		2321 Silverway Gambrills, Md. 21054	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Respiratory Failure						Unknown	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure						unknown	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
Fracture Right Hip							
19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
11/1/86		Intracranial Frac (R) Hip		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
N/A		None N/A		Unknown N/A			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
N/A		N/A		N/A			
I certify that (I) (this hospital) attended the deceased from 12/10/86 to 12/10/86, that (I) (we) last saw the deceased alive on 12/10/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Wm G. Ables						12/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
DABBS, W. A.		703 GIDDINGS AVE.					
23a. FUNERAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		12/15/86		ST JOHNS EPISCOPAL		BELTSVILLE, P.G.MD.	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN.		DEC 12 1986		Julia Sanders-Randall			

05/11/2018

11/11/2018

2018



Handwritten notes and signatures, including a large 'X' and various illegible markings.

027148 DEC 15 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Denise Ann Heitman</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12/ 7/ 19 86</b>			2b. HOUR <b>M</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12-28-1958</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>27</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12/ 7/ 1986</b>			2d. HOUR <b>10:01 P M</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School Bus</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>AACo</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earl H. Heitman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Warfield</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>214-52-9714</b>			17. INFORMANT <b>Earl H. Heitman</b>			17. ADDRESS <b>Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 12/ 7/19 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted wound</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1359 Severn Rd., Glen Burnie, Anne Arundel, Md.</b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Gregory R. Kauffman, M.D.</b>			TITLE (SPECIFY) <b>Assistant MEDICAL EXAMINER</b>					DATE SIGNED <b>12/8/86</b>	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <b>111 Penn St.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/10/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie AACo Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home</b>			ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 12 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John ...</b>		

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

NOTES



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19B shows any injury, or other significant event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Betty Jane Hollidayoke</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec. 29, 1986</b>		2b. HOUR <b>3:13 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Sept. 6, 1933</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.
10 CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3181 Raven Court</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Dan Elam</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Belle Lowe</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-48-3600</b>
17 INFORMANT <b>Dennis F. Hollidayoke</b>		18 ADDRESS <b>Same as #13</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Breast Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> 19 <b>84</b> to <b>December</b> 19 <b>86</b> that (I) (we) lost saw the deceased alive on <b>Dec 11</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>A. Caputo</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-29-86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Caputo MD</b>		22e. ADDRESS <b>132 Holiday Court, Annapolis MD</b>				
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>Burial</b>		23b. DATE <b>Dec 31, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Anne's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>
24 FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis, MD</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Radner</b>

1. The first part of the document  
describes the general situation  
and the objectives of the project.  
It also mentions the main  
participants and the scope of the  
work.

2. The second part of the document  
contains a detailed description of the  
methodology used in the study.  
This includes the data collection  
methods, the analysis techniques,  
and the results of the study.

3. The third part of the document  
presents the conclusions of the study  
and discusses the implications of the  
findings. It also includes a list of  
references and an appendix.

BP

DHMM - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other trauma, a medical examiner must be notified at once.027553 DEC 18 86  
FOR STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JENNIE E Hooper</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-15-86</b>		2b. HOUR <b>7:30A</b> M.		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 07 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York, N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.	
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>316 Park Hall South</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Crawford</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Faigle</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>-----</b>			
16b. SOCIAL SECURITY NO. <b>075-40-9079</b>		17. INFORMANT ADDRESS <b>Walter Hooper same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Painless Jaundice</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-----</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-3-86</b> , to <b>12-15-86</b> , that (I) (we) lost saw the deceased alive on <b>12-15-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Rolando V. Goco</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-15-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rolando V. Goco, MD</b>		22e. ADDRESS <b>9101 Cherry Lane, Laurel, Md. 20707</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/15/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Wash. Crematory</b>		23d. LOCATION CITY STATE <b>Laurel P.G. Md. STATE</b>	
24. FUNERAL DIRECTOR NAME <b>Fleck Funeral Home Laurel, Md. 20707</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1986</b>		25b. REGISTRAR'S SIGNATURE <b>A. A. Henderson-Randall</b>	

MEDICAL CERTIFICATION



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027003 DEC 15 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RALPH Bonner HUDNELL Jr.</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>12 10 1986</b>			2b. HOUR <b>9 a.m.</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 15, 1926</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>60</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 10 1986</b>	2d. HOUR <b>9 a.m.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.		
11. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING</b>	
13a. STATE <b>N.C.</b>		13b. COUNTY <b>Beaufort</b>	13c. CITY OR TOWN <b>AURORA</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>Rte 2 27806</b>		99999	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Bonner Hudnell, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Bennett</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>241-32-8478</b>		17. INFORMANT <b>Aurora, N.C. 27806</b> <b>Mary Hudnell, Rte 2 Box 43</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>TOBACCO ABUSE</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Charles A. Seager</b> M.D.				TITLE (SPECIFY) <b>DEPUTY</b>		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>CHARLES A. SEAGER</b>				ADDRESS <b>780 RITCHIE HWY SUITE</b>		DATE SIGNED <b>12/10/86</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 13, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dublin Grove Church</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aurora, Beaufort, N.C.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b> <b>6009 Harford Rd., Balto., Md. 21214</b>				25. DATE REC'D BY REGISTRAR <b>DEC 11 1986</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PHA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

0311-1750



026229 DEC-5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN HUNTER			2a. DATE OF DEATH MONTH DAY YEAR 12 2 86		2b. HOUR 9:15 P.M.
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 9 13 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Kirby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Gross		16. STREET ADDRESS / ZIP CODE 130 HEARN RD. 21401	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-26-0422A		17. INFORMANT ADDRESS LENA ELLIOTT-310 West St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour
DUE TO, OR AS A CONSEQUENCE OF (b) <del>AS</del> CARDIAC Arrhythmia					18 hrs. Excrant.
DUE TO, OR AS A CONSEQUENCE OF (c) <del>AS</del> ULD MS					18 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension Suspected Bacterial CA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 68 to 19 86, that (I) (we) lost saw the deceased alive on 12/2/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. R.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 18/6/86		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. Md.		23e. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 4 1986			
24. FUNERAL DIRECTOR NAME William Keese + Sons Mortuary, A.A. 821 West St.					

BP \_\_\_\_\_

1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

2. The second part of the report is a detailed description of the project's progress. It includes a list of the tasks that have been completed and a list of the tasks that are still in progress.

3. The third part of the report is a discussion of the project's results. It includes a list of the findings that have been obtained and a list of the conclusions that have been drawn.

4. The fourth part of the report is a discussion of the project's future. It includes a list of the recommendations that have been made and a list of the actions that are planned to be taken.

5. The fifth part of the report is a list of the references that have been used in the project. It includes a list of the books, articles, and other sources that have been consulted.

6. The sixth part of the report is a list of the appendices that have been included in the project. It includes a list of the tables, figures, and other materials that have been used.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Archibald Robert James			MONTH DAY YEAR 12-13-1986			8:30 P		
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	Caucasian	MONTH DAY YEAR 12-19-1902	83 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Utah	U.S.A.		Anne Shundel Co. MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Severna Park	122 St. Andrews Rd		employee			Postal Service		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland	A.A.	Severna Park	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			122 St. Andrews Rd 21146		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
MARK Utah		Elizabeth Tonge						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO		529502675		ARABELLA James 122 St. Andrews Rd 21146				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>cancer of right lung</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>86</u> , to <u>Dec</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>about 12/11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE					22c. DATE SIGNED	
<u>James J. Benjamin MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					12/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
James J. Benjamin		653 CH Mill Rd. Millersville MD 21108						
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		12/19/86		Midvale Cemetery		Midvale, Utah		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
BARRANCO F.H. 501 RITCHIE HWY. SEVERNA PARK MD 21146		DEC 19 1986		John Anderson-Ridner				

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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EXCUTION COPY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUBY E. M. JORDAN			2a. DATE OF DEATH MONTH DAY YEAR 12/5/-86		2b. HOUR 5:15 PM
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 01/19/21		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (AAGH) Anne Arundel Gen Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md			13b. COUNTY A. A	13c. CITY OR TOWN Millerville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thaddeus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Mae Corprew			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-20-0017		17. INFORMANT ADDRESS William Jordan 3 Overlea Ave	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b) multiple sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>86</u> , to <u>12-5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Peterson		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-5-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Peterson		22e. ADDRESS 25 Shaw St Annapolis Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/10/86	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Md
24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home West 4300 Wabash Avenue			25a. DATE REC'D. BY REGISTRAR DEC 10 1986

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8633521			
1. FOR STATE REGISTRAR				EST			
1. DECEASED NAME (Type in print) FIRST MIDDLE LAST ALBERT BERTERAM KEEN				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 22, 1986		2b. HOUR 540 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 30, 1905		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Businessman		12b. KIND OF BUSINESS OR INDUSTRY Financial	
13a. STATE Maryland				13b. COUNTY A.A. Co.		13c. CITY OR TOWN Severna Park	
14. FATHER'S NAME FIRST MIDDLE LAST Bertram Alec Keen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Hurst		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes				17b. SOCIAL SECURITY NO. 062-07-7593		17c. INFORMANT ADDRESS Kathryn Keen 612 Pinetree Dr. 21146	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I): <u>Renal Failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Hours</u>
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ADOPSED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 12-7 St 12-22 St	
22. I certify that (I) (this hospital) attended the deceased from <u>12-7</u> 19 <u>86</u> to <u>12-22</u> 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>12-23</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>Hilary T. O'Herlihy</u>				DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 12-22-86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) HILARY T. O'HERLIHY				22d. ADDRESS 525 HOSPITAL DRIVE SUITE 208 GLEN BURNIE, MARYLAND 21060			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/26/86		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard MD	
24. FUNERAL DIRECTOR NAME ADDRESS Barranco F.H. 501 Ritchie Hwy. Sev Pk 21146				25a. DATE REC'D. BY REGISTRAR DEC 29 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

*[Faint, illegible handwritten text covering the majority of the page, possibly bleed-through from the reverse side.]*

THE SECRETARY OF THE

DEPARTMENT OF THE

0277735

FOR  
STATES  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

3 3 5 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Gladys N Kelley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec. 14 1986</b> 2b. HOUR <b>11:15 PM</b>		
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 26 1901</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		
10. CITY OR TOWN OF DEATH <b>Edgewater</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Living Convalescent Ctr.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerical</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Stationary</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland A.A. Arnold</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>BURT Springer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAE Graham</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE NUMBER OR PREFIX) <b>WA 484280975</b>		17. INFORMANT ADDRESS <b>Dale H. Odell (Same as above)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Aspiration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF, (c) <b>Aspiration</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) <b>Severe DSD, female CVA</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>84</b> , to <b>12/14</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11/15/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Errol A. Gill</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/15/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ERROL A. GILL</b>		22e. ADDRESS <b>1835 Forest Drive Lane, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>12-18-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crem</b>	
23d. LOCATION CITY OR TOWN COUNTY <b>Westview, A.A. MD</b>		23e. DATE REC'D. BY REGISTRAR <b>DEC 19 1986</b>		23f. REGISTRAR'S SIGNATURE <b>Julia Deaton-Richard</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>BARRANCO F.H. 501 Ritchie Hwy Severna Park, MD</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Page 1B should be filed with the medical examiner's office if the medical examiner has been notified.

IMPORTANT: Step 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner should be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as per flight of air.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 2 9

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) UN NYUN KIM			2a. DATE OF DEATH MONTH DAY YEAR 12 30 86			2b. HOUR 9:00 a.m.	
3. SEX FEMALE		4. RACE ORIENTAL		5. DATE OF BIRTH MONTH DAY YEAR 3 8 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Korea		7b. CITIZEN OF WHAT COUNTRY? South Korea		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 120 Crain Highway Apt 894				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Homemaker		13. CITY OR TOWN OF DEATH Glen Burnie					
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 120 Crain Highway Apt 894		14. FATHER'S NAME FIRST MIDDLE LAST HAK SOO KIM					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. 218 78 0144		17. INFORMANT Glen Burnie, Maryland 21061 Ruby Graulich 805 Scott Circle					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anteroseptal Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Sang C. Do H. M.D.</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12-30-86			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DO H. M.D.		22f. ADDRESS 95 Aqueduct Rd Glen Burnie, MD 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR NAME Raymond C. Fink Glen Burnie, Md 21061				25a. DATE REC'D. BY REGISTRAR DEC 31 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

BP



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James A. King Sr.			2a. DATE OF DEATH MONTH DAY YEAR Dec. 8, 1986		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 16 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy
13a. STATE Md.			13b. COUNTY A.A. Co.	13c. CITY OR TOWN Deale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME Arly Calvin King		15. MOTHER'S MAIDEN NAME Beatrice Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 443-10-8160	17. INFORMANT Lillie Mae King #13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULM EMBOLUS. Presumed</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>METASTATIC Ca</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>COPD.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1976</u> to <u>Dec 8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Harvey J. Steinfeld</u>		DEGREE MD		22c. DATE SIGNED 12/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY J STEINFELD		22e. ADDRESS SHADYSIDE Md 20764			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 12-9-86	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION Brentwood P.G. Md. STATE	
24. FUNERAL DIRECTOR NAME T.A. Hardesty			ADDRESS Annapolis, Maryland		
25a. DATE REC'D. BY REGISTRAR DEC 12 1986			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

BP

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33531

1. DECEASED NAME (TYPE OR PRINT) <b>Marjorie Louise King</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 18 86</b>		2b. HOUR M <b>0734</b>
3. SEX <b>F</b>	4. RACE <b>Neg</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 19 10</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>75 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>FA.</b>
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dept of Army</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Irving W. Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary L. Harris</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-32-0713</b>		
17. INFORMANT <b>Garland A. King, Sr</b>		ADDRESS <b>1214 Louisiana</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>As CVD.</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>William P. Jones</b>		TITLE (SPECIFY) <b>M.D. Deputy</b>		MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>		ADDRESS <b>695 America Crt. Davidsonville Md. 21035</b>		
23a. BURIAL, CREMATION, REMOVAL	23b. DATE <b>12-23-1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILL Crest</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>C. E. Hicks #1922 Forest Drive</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 29 1986</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, "GIVE PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR 215 ME (5))



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Severna Kipp</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 01 86</b>			2b. HOUR <b>9<sup>50</sup> A M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04-13-1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>BROOKLYN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>SEVERNA PK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>447 HOLY FARMS RD / 21146</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB ODBRECHT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>			17 INFORMANT <b>JOHN KIPP II</b>			ADDRESS <b>(SAME AS 13)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Cell Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>7-30</b> , 19 <b>81</b> , to <b>12-1</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>11-7</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Michael Schwartz</b>			DEGREE			22c. DATE SIGNED <b>12-1-86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL SCHWARTZ</b>			22e. ADDRESS <b>606 HAMMONDS LA. - Brooklyn 21225 Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>12-2-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WESTVIEW BALT. Co. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>BARRANCO F. H.</b>			495 RITCHIE HWY. ADDRESS <b>SEVERNA PARK, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Lia Anderson-Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2, which should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please return the remaining pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, then item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 3 3 5 3 3	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				REG. NO.	
ELWOOD STANLEY KOERNER				SR DECEMBER 26 1986 914 M PM	
3 SEX		4 RACE		5. DATE OF BIRTH	
Male		White		MONTH DAY YEAR 1 24 10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
Maryland		U.S.A.		76 YRS.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		ANNE ARUNDEL COUNTY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Tarf Dept.		Railroad			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		A.A.		Pasadena	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		1945 Cedar Road 21122	
Harry W. Koedner		Helen M. Salfner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
NO		705-05-5384		Louise Koerner 1945 Cedar Road 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolus</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Deep Venous Thrombosis - Right Lower Extremity</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
<u>Cerebral Vascular Accident</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , 19 <u>86</u> , to <u>12/26</u> , 19 <u>86</u> , that (I) (we) lost					
saw the deceased alive on <u>12/26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>[Signature]</u>				<u>12/27/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DR. GIORA A. PRAFF, M. D.		1404 CRAIN HWY., S., SUITE 300 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/30/86		Loudon Park Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE	
				Baltimore Maryland	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc.		4107 Wilkens Ave. 21229		DEC 29 1986 <u>[Signature]</u>	



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED MONTH DAY YEAR		2b. HOUR	
Donald						Lambert, Sr				12 16 1986		0703	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	NEG	8 15 32		54 YRS.						12 16 1986		0703	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH	
DELEWARE		U.S.A.										A A	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel Gen											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md		AA		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2140					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
WILLIAM		TAILBETT		SARAH		LAMBERT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		222-18-4854		Annapolis, Md. 21401		PHYLLIS R. LAMBERT		212		Gross Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cardiac Arrest													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.													
(b) A.S.C.U.D.													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Hypertension													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
Chronic / Acute Chemical Intoxication													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
William P. Jones, M.D.				M.D. Deputy				12/16/86					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
William P. Jones, M.D.				695 America Crt. Davidsonville, Md 21035									
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL				12-21-1986				GRACE LAWN MEM. PARK				New Castle Deleware	
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Annapolis, Md. 21401								DEC 18 1986		John Sanderford			
WILLIAM REESE & SONS MORTUARY, P.A.													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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Main body of handwritten text, including a circular stamp or logo in the center.

029463 JAN 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33535

1. DECEASED NAME (TYPE OR PRINT) <b>Charles F. LaRogue</b>				2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> 12 DAY 29 YEAR 1986				2b. HOUR M 15	
3. SEX <b>M</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH 11 DAY 9 YEAR 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Vermont</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
13a. STATE <b>Md</b>				13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Arnold</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leon John LaRogue</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Steer</b>				16. SOCIAL SECURITY NO. <b>215-38-9270</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes WWII</b>				17. INFORMANT <b>Dorothy Carter</b>				18. ADDRESS <b>1014 1/2 Tyler Ave. Annapolis, MD 21403</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Multiple Trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). <b>Motor Vehicle Acc.</b> DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								22b. TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER	
ACTUAL SIGNATURE <b>William P. Jones</b>				DATE SIGNED <b>12/29/86</b>				22c. EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>				23b. DATE <b>Jan 2, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Lindner</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM W-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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029324 JAN - 8

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JASON THOMAS LEITCH</b>			2a. DATE KNOWN OF DEATH MONTH <b>12</b> DAY <b>26</b> YEAR <b>1986</b> HOUR <b>10</b> MIN <b>30</b> PM	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>12</b> YEAR <b>1969</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>17</b> YRS.	7. IF UNDER 1 YR. MONTHS <b>17</b> DAYS <b>17</b> HOURS <b>17</b> MIN <b>17</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNAPOLIS</b> MD.
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12c. KIND OF BUSINESS OR INDUSTRY <b>High School</b>
13a. STATE <b>MD</b>	13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Davidsonville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>1754 Lerch Farm Court</b>
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>L.</b> LAST <b>Leitch, Jr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Rollin</b> MIDDLE <b>Cooper</b> LAST <b>Cooper</b>		16. SOCIAL SECURITY NO. <b>220-04445</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-04445</b>		17. INFORMANT <b>Thomas L. Leitch, Jr.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK DUE TO MULTIPLE INJURIES</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <b>8147</b> (b) <b>MOTOR VEHICLE ACCIDENT</b> (c) <b>SECONDS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SECONDS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10:30 PM 12 26 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>PEDESTRIAN STRUCK BY AUTO</b>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>STREET</b>		21f. LOCATION STREET <b>PATUXANT ROAD</b> CITY OR TOWN <b>DAVIDSONVILLE</b> COUNTY <b>AA</b> STATE <b>MD</b>
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE <b>L. L. Seager, MD</b>		TITLE (SPECIFY) <b>DEPUTY</b>		DATE SIGNED <b>12/27/86</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>CHARLES A. SEAGER</b>		ADDRESS <b>780 RITCHIE HWY, SUK</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 31, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakemont</b>	
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 10-1, 10-2, 10-3, 10-4, 10-5, 10-6, 10-7, 10-8, 10-9, 10-10, 10-11, 10-12, 10-13, 10-14, 10-15, 10-16, 10-17, 10-18, 10-19, 10-20, 10-21, 10-22, 10-23, 10-24, 10-25, 10-26, 10-27, 10-28, 10-29, 10-30, 10-31, 10-32, 10-33, 10-34, 10-35, 10-36, 10-37, 10-38, 10-39, 10-40, 10-41, 10-42, 10-43, 10-44, 10-45, 10-46, 10-47, 10-48, 10-49, 10-50, 10-51, 10-52, 10-53, 10-54, 10-55, 10-56, 10-57, 10-58, 10-59, 10-60, 10-61, 10-62, 10-63, 10-64, 10-65, 10-66, 10-67, 10-68, 10-69, 10-70, 10-71, 10-72, 10-73, 10-74, 10-75, 10-76, 10-77, 10-78, 10-79, 10-80, 10-81, 10-82, 10-83, 10-84, 10-85, 10-86, 10-87, 10-88, 10-89, 10-90, 10-91, 10-92, 10-93, 10-94, 10-95, 10-96, 10-97, 10-98, 10-99, 10-100, 10-101, 10-102, 10-103, 10-104, 10-105, 10-106, 10-107, 10-108, 10-109, 10-110, 10-111, 10-112, 10-113, 10-114, 10-115, 10-116, 10-117, 10-118, 10-119, 10-120, 10-121, 10-122, 10-123, 10-124, 10-125, 10-126, 10-127, 10-128, 10-129, 10-130, 10-131, 10-132, 10-133, 10-134, 10-135, 10-136, 10-137, 10-138, 10-139, 10-140, 10-141, 10-142, 10-143, 10-144, 10-145, 10-146, 10-147, 10-148, 10-149, 10-150, 10-151, 10-152, 10-153, 10-154, 10-155, 10-156, 10-157, 10-158, 10-159, 10-160, 10-161, 10-162, 10-163, 10-164, 10-165, 10-166, 10-167, 10-168, 10-169, 10-170, 10-171, 10-172, 10-173, 10-174, 10-175, 10-176, 10-177, 10-178, 10-179, 10-180, 10-181, 10-182, 10-183, 10-184, 10-185, 10-186, 10-187, 10-188, 10-189, 10-190, 10-191, 10-192, 10-193, 10-194, 10-195, 10-196, 10-197, 10-198, 10-199, 10-200, 10-201, 10-202, 10-203, 10-204, 10-205, 10-206, 10-207, 10-208, 10-209, 10-210, 10-211, 10-212, 10-213, 10-214, 10-215, 10-216, 10-217, 10-218, 10-219, 10-220, 10-221, 10-222, 10-223, 10-224, 10-225, 10-226, 10-227, 10-228, 10-229, 10-230, 10-231, 10-232, 10-233, 10-234, 10-235, 10-236, 10-237, 10-238, 10-239, 10-240, 10-241, 10-242, 10-243, 10-244, 10-245, 10-246, 10-247, 10-248, 10-249, 10-250, 10-251, 10-252, 10-253, 10-254, 10-255, 10-256, 10-257, 10-258, 10-259, 10-260, 10-261, 10-262, 10-263, 10-264, 10-265, 10-266, 10-267, 10-268, 10-269, 10-270, 10-271, 10-272, 10-273, 10-274, 10-275, 10-276, 10-277, 10-278, 10-279, 10-280, 10-281, 10-282, 10-283, 10-284, 10-285, 10-286, 10-287, 10-288, 10-289, 10-290, 10-291, 10-292, 10-293, 10-294, 10-295, 10-296, 10-297, 10-298, 10-299, 10-300, 10-301, 10-302, 10-303, 10-304, 10-305, 10-306, 10-307, 10-308, 10-309, 10-310, 10-311, 10-312, 10-313, 10-314, 10-315, 10-316, 10-317, 10-318, 10-319, 10-320, 10-321, 10-322, 10-323, 10-324, 10-325, 10-326, 10-327, 10-328, 10-329, 10-330, 10-331, 10-332, 10-333, 10-334, 10-335, 10-336, 10-337, 10-338, 10-339, 10-340, 10-341, 10-342, 10-343, 10-344, 10-345, 10-346, 10-347, 10-348, 10-349, 10-350, 10-351, 10-352, 10-353, 10-354, 10-355, 10-356, 10-357, 10-358, 10-359, 10-360, 10-361, 10-362, 10-363, 10-364, 10-365, 10-366, 10-367, 10-368, 10-369, 10-370, 10-371, 10-372, 10-373, 10-374, 10-375, 10-376, 10-377, 10-378, 10-379, 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10-630, 10-631, 10-632, 10-633, 10-634, 10-635, 10-636, 10-637, 10-638, 10-639, 10-640, 10-641, 10-642, 10-643, 10-644, 10-645, 10-646, 10-647, 10-648, 10-649, 10-650, 10-651, 10-652, 10-653, 10-654, 10-655, 10-656, 10-657, 10-658, 10-659, 10-660, 10-661, 10-662, 10-663, 10-664, 10-665, 10-666, 10-667, 10-668, 10-669, 10-670, 10-671, 10-672, 10-673, 10-674, 10-675, 10-676, 10-677, 10-678, 10-679, 10-680, 10-681, 10-682, 10-683, 10-684, 10-685, 10-686, 10-687, 10-688, 10-689, 10-690, 10-691, 10-692, 10-693, 10-694, 10-695, 10-696, 10-697, 10-698, 10-699, 10-700, 10-701, 10-702, 10-703, 10-704, 10-705, 10-706, 10-707, 10-708, 10-709, 10-710, 10-711, 10-712, 10-713, 10-714, 10-715, 10-716, 10-717, 10-718, 10-719, 10-720, 10-721, 10-722, 10-723, 10-724, 10-725, 10-726, 10-727, 10-728, 10-729, 10-730, 10-731, 10-732, 10-733, 10-734, 10-735, 10-736, 10-737, 10-738, 10-739, 10-740, 10-741, 10-742, 10-743, 10-744, 10-745, 10-746, 10-747, 10-748, 10-749, 10-750, 10-751, 10-752, 10-753, 10-754, 10-755, 10-756, 10-757, 10-758, 10-759, 10-760, 10-761, 10-762, 10-763, 10-764, 10-765, 10-766, 10-767, 10-768, 10-769, 10-770, 10-771, 10-772, 10-773, 10-774, 10-775, 10-776, 10-777, 10-778, 10-779, 10-780, 10-781, 10-782, 10-783, 10-784, 10-785, 10-786, 10-787, 10-788, 10-789, 10-790, 10-791, 10-792, 10-793, 10-794, 10-795, 10-796, 10-797, 10-798, 10-799, 10-800, 10-801, 10-802, 10-803, 10-804, 10-805, 10-806, 10-807, 10-808, 10-809, 10-810, 10-811, 10-812, 10-813, 10-814, 10-815, 10-816, 10-817, 10-818, 10-819, 10-820, 10-821, 10-822, 10-823, 10-824, 10-825, 10-826, 10-827, 10-828, 10-829, 10-830, 10-831, 10-832, 10-833, 10-834, 10-835, 10-836, 10-837, 10-838, 10-839, 10-840, 10-841, 10-842, 10-843, 10-844, 10-845, 10-846, 10-847, 10-848, 10-849, 10-850, 10-851, 10-852, 10-853, 10-854, 10-855, 10-856, 10-857, 10-858, 10-859, 10-860, 10-861, 10-862, 10-863, 10-864, 10-865, 10-866, 10-867, 10-868, 10-869, 10-870, 10-871, 10-872, 10-873, 10-874, 10-875, 10-876, 10-877, 10-878, 10-879, 10-880, 10-881, 10-882, 10-883, 10-884, 10-885, 10-886, 10-887, 10-888, 10-889, 10-890, 10-891, 10-892, 10-893, 10-894, 10-895, 10-896, 10-897, 10-898, 10-899, 10-900, 10-901, 10-902, 10-903, 10-904, 10-905, 10-906, 10-907, 10-908, 10-909, 10-910, 10-911, 10-912, 10-913, 10-914, 10-915, 10-916, 10-917, 10-918, 10-919, 10-920, 10-921, 10-922, 10-923, 10-924, 10-925, 10-926, 10-927, 10-928, 10-929, 10-930, 10-931, 10-932, 10-933, 10-934, 10-935, 10-936, 10-937, 10-938, 10-939, 10-940, 10-941, 10-942, 10-943, 10-944, 10-945, 10-946, 10-947, 10-948, 10-949, 10-950, 10-951, 10-952, 10-953, 10-954, 10-955, 10-956, 10-957, 10-958, 10-959, 10-960, 10-961, 10-962, 10-963, 10-964, 10-965, 10-966, 10-967, 10-968, 10-969, 10-970, 10-971, 10-972, 10-973, 10-974, 10-975, 10-976, 10-977, 10-978, 10-979, 10-980, 10-981, 10-982, 10-983, 10-984, 10-985, 10-986, 10-987, 10-988, 10-989, 10-990, 10-991, 10-992, 10-993, 10-994, 10-995, 10-996, 10-997, 10-998, 10-999, 1100

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DHMH - 17  
(VR A15 ME (5))



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 3 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) HELEN MARION LESNIEWSKI			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 08, 1986		2b. HOUR 9.28 PM
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 5 28 20	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET.	12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1419 GORDON Dr 21061
14. FATHER'S NAME FIRST MIDDLE LAST JOHN N. RIDLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VICTORIA NOWAK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-05-0761		17. INFORMANT ADDRESS MRS DORIS MAXWELL 30 SHAWNGT 21236	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/27/86, 19 86, to 12/8/86, 19 86, that (I/we) last saw the deceased alive on 12/12/86, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED 12/16/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B KROOPNICK, M.D.

22e. ADDRESS 95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

23b. DATE 12-12-86

23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem

23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE Co. MD.

24. FUNERAL DIRECTOR NAME ADDRESS KACZOROWSKI FUNERAL HOME 2525 Fleet St.

25a. DATE REC'D. BY REGISTRAR DEC 11 1986

25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove this certificate. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

BP

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029247 JAN 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Richard			MIDDLE G.			LAST Lynch			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 12/			DAY 27/			YEAR 1986			2b. HOUR 9:00 A M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 10 1942		6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 12/ 27/ 1986			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Educator				12b. KIND OF BUSINESS OR INDUSTRY Education									
13a. STATE Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Laurel				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14800 Fourth Street 20707															
14. FATHER'S NAME FIRST MIDDLE LAST George Lynch						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Williams						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No						16b. SOCIAL SECURITY NO. 053-36-8525						17. INFORMANT ADDRESS Geraldine Anderson RD.1 Box 235 Slate Hill, NY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>										TITLE (SPECIFY) Assistant MEDICAL EXAMINER										DATE SIGNED 12/28/86									
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.						ADDRESS 111 Penn St.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 1-3-87						23c. NAME OF CEMETERY OR CREMATORY Ridgebury Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Ridgebury, Orange, New York											
24. FUNERAL DIRECTOR NAME ADDRESS Marzullo Funeral Service Upperco, MD.												25a. DATE REC'D. BY REGISTRAR DEC 31 1986				25b. REGISTRAR'S SIGNATURE <i>Julius Anderson-Rodgers</i>													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

05371-7020

RECEIVED THE DIRECTOR  
OF THE BUREAU OF THE  
INTERNAL SECURITY OF THE  
UNITED STATES DEPARTMENT OF JUSTICE

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible, appearing to be a memorandum or report body.]



05371-7020

RECEIVED THE DIRECTOR  
OF THE BUREAU OF THE  
INTERNAL SECURITY OF THE  
UNITED STATES DEPARTMENT OF JUSTICE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

128449 DEC 29 1986

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		6:45 P.M.	
DOROTHY R MALAN		12 21 86			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	83 YRS	MONTHS DAYS HOURS MIN.	
February 19, 1903					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
N. Carolina	United States	9. BALTIMORE CITY OR COUNTY OF DEATH			
		Anne Arundel MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	Anne Arundel General Hosp		Nursing		Hospital
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE	
13a. STATE		13b. COUNTY	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4 St. Ives Drive 21146	
Md.		A.A.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
John Rogers		Irma Walker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		none 216-12-9396		Mrs. Mary Sue Clark (same as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Aortic Stenosis, CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 12/18/86, to 12/21/86, that (1) (we) last saw the deceased alive on 12/20/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE EW Cole III		DEGREE MD		22c. DATE SIGNED 12/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EW COLE III		22e. ADDRESS 51 FRANKLIN ST ANNAP. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-23-1986		23c. NAME OF CEMETERY OR CREMATORY Loudon Park	
				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md.	
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO		25a. DATE REC'D. BY REGISTRAR DEC 29 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
		SEVERNA PARK, MD. 21146			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be a list or series of entries, possibly describing plant specimens or experimental results. Some legible fragments include "No. 1", "No. 2", "No. 3", "No. 4", "No. 5", "No. 6", "No. 7", "No. 8", "No. 9", "No. 10", "No. 11", "No. 12", "No. 13", "No. 14", "No. 15", "No. 16", "No. 17", "No. 18", "No. 19", "No. 20", "No. 21", "No. 22", "No. 23", "No. 24", "No. 25", "No. 26", "No. 27", "No. 28", "No. 29", "No. 30", "No. 31", "No. 32", "No. 33", "No. 34", "No. 35", "No. 36", "No. 37", "No. 38", "No. 39", "No. 40", "No. 41", "No. 42", "No. 43", "No. 44", "No. 45", "No. 46", "No. 47", "No. 48", "No. 49", "No. 50", "No. 51", "No. 52", "No. 53", "No. 54", "No. 55", "No. 56", "No. 57", "No. 58", "No. 59", "No. 60", "No. 61", "No. 62", "No. 63", "No. 64", "No. 65", "No. 66", "No. 67", "No. 68", "No. 69", "No. 70", "No. 71", "No. 72", "No. 73", "No. 74", "No. 75", "No. 76", "No. 77", "No. 78", "No. 79", "No. 80", "No. 81", "No. 82", "No. 83", "No. 84", "No. 85", "No. 86", "No. 87", "No. 88", "No. 89", "No. 90", "No. 91", "No. 92", "No. 93", "No. 94", "No. 95", "No. 96", "No. 97", "No. 98", "No. 99", "No. 100".

029119 JAN - 1987
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
86 33540

**CERTIFICATE OF DEATH**

REG. NO. EST.

1. DECEASED NAME (TYPE OR PRINT)  
**Lolette Loretta C. Marlowe**

2a. DATE OF DEATH MONTH DAY YEAR  
**December 28, 1986**

2b. HOUR P  
**9:00 AM**

3. SEX  
**Female**

4. RACE  
**White**

5. DATE OF BIRTH MONTH DAY YEAR  
**December 29, 1914**

6. AGE (IN YEARS LAST BIRTHDAY)  
**71** YRS.

IF UNDER 1 YEAR  
 MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Maryland**

7b. CITIZEN OF WHAT COUNTRY?  
**United States**

8. MARRIED ☐ NEVER MARRIED ☐  
 WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**Anne Arundel** MD.

10. CITY OR TOWN OF DEATH  
**Glen Burnie**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**7885 Gordon Ct.**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Retired**

12b. KIND OF BUSINESS OR INDUSTRY  
**Factory**

13a. STATE  
**Maryland**

13b. COUNTY  
**Anne Arundel**

13c. CITY OR TOWN  
**Glen Burnie**

13d. INSIDE CITY LIMITS?  
 YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE  
**7885 Gordon Ct. 21061**

14. FATHER'S NAME FIRST MIDDLE LAST  
**Luther D. Hurley**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Mary (Unknown)**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
**No**

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  
**236 09 6202**

17. INFORMANT ADDRESS  
**Mary Jo Shehane 229 Magothy Beach Rd. Pasadena, MD 21122**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) **Myocardial Infarction**  
 DUE TO, OR AS A CONSEQUENCE OF (b) **ASCVD**  
 DUE TO, OR AS A CONSEQUENCE OF (c) **COPD**  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
**1 m 43 s**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **no**

19a. DATE OF OPERATION  
**3/31/86**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
**ASCVD**

20a. AUTOPSY?  
 YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
 YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
**no**

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  
**no**

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK  
**no**

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
**no**

21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
**no**

22a. I certify that (I) (this hospital) attended the deceased from **3/31/86**, 19 **86**, to **12/28**, 19 **86**, that (I) (we) last saw the deceased alive on **11-21**, 19 **86**, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE  
**C. Thomas Folkemer, M.D.**

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED  
**12/30/86**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**C. Thomas Folkemer, M.D.**

22e. ADDRESS  
**4141 Mountain Rd., Pasadena, Md. 21122**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**Burial**

23b. DATE  
**Dec. 31, '86**

23c. NAME OF CEMETERY OR CREMATORY  
**Woodlawn Cemetery**

23d. LOCATION CITY OR TOWN COUNTY STATE  
**Baltimore Woodlawn MD**

24. FUNERAL DIRECTOR NAME ADDRESS  
**McCully Funeral Homes 3204 Mountain Rd. Pasadena, MD 21122**

25a. DATE REC'D. BY REGISTRAR  
**JAN 2 1987**

25b. REGISTRAR'S SIGNATURE  
**Julia Davidson-Randall**

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place in the container with the deceased. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DHMH - 16 50M 4/83  
 (VRA 15, 4)



029053 JAN - 5 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86-33541

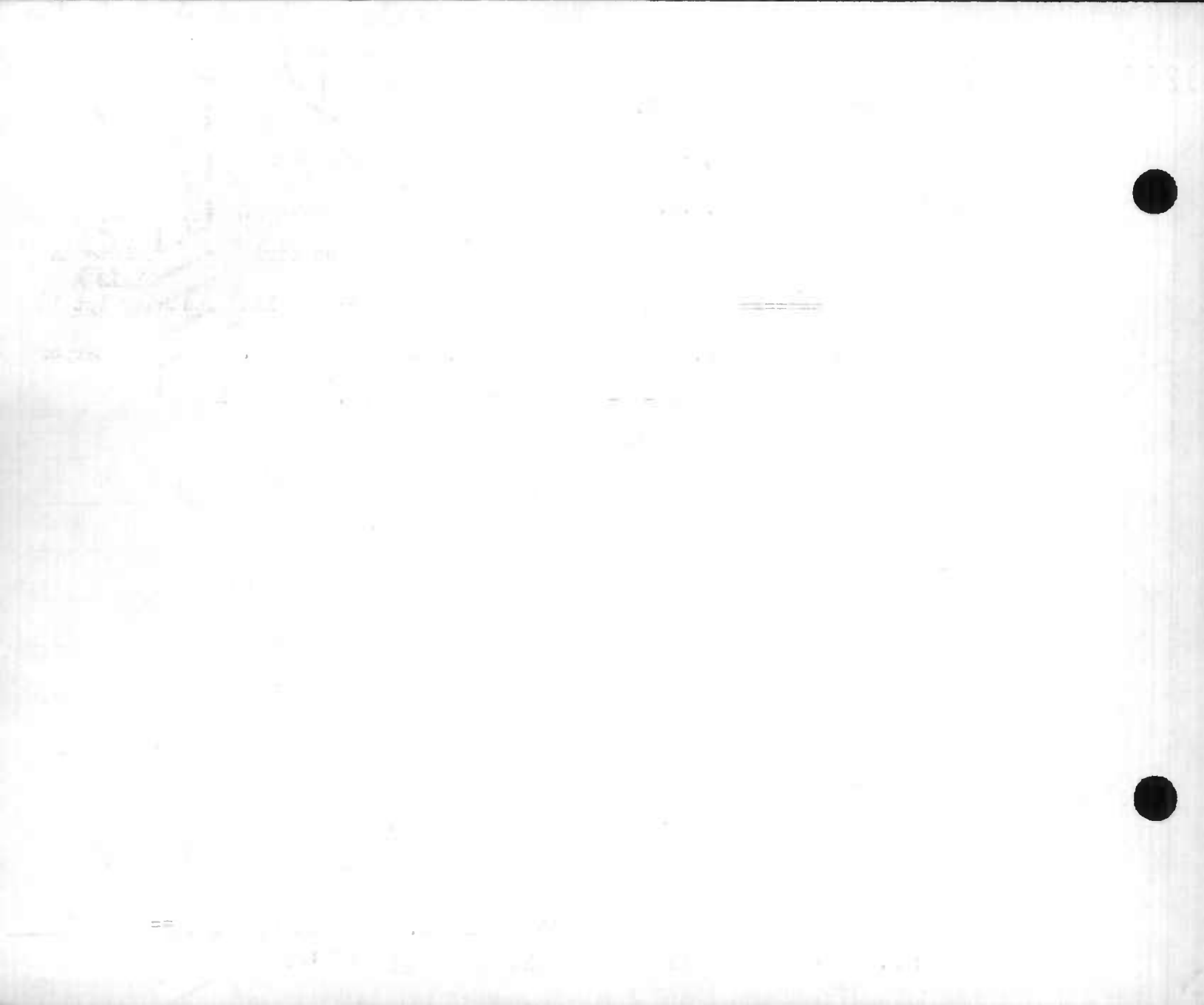
REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FLORENCE C. MASKEll</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-25 86</b>			2b. HOUR / <b>A</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-15-08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78 yrs</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.				
12. CITY OR TOWN OF DEATH <b>BROOKLYN PK.</b>			13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Hammonds Lane Center</b>			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bus Girl</b>			15. KIND OF BUSINESS OR INDUSTRY <b>Cafeteria</b>	
16. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b> 16b. COUNTY <b>=====</b> 16c. CITY OR TOWN <b>Baltimore</b>			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			18. STREET ADDRESS / ZIP CODE <b>351 Homeland Southway Apt 1D 21212</b>				
19. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas J. Maskell</b>			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna C. Harper</b>							
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			22. SOCIAL SECURITY NO. <b>216-24-8817</b>			23. INFORMANT ADDRESS <b>Leonard Beam Jr. Same as 13e</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF: (b) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>									
DUE TO, OR AS A CONSEQUENCE OF: (c) <b>MULTIPLE DECUBITII</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Peripheral Vascular Insufficiency. HYPOTHY.</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 18</b> 19 <b>79</b> to <b>Dec. 26</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12/25</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Harjit Singh</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/26/86.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARJIT SINGH M.D.</b>			22e. ADDRESS <b>#8, 16th AVE, BALTIMORE, Md. - 21228.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/30/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore == Md</b>		
24. FUNERAL DIRECTOR <b>George J. Gonce</b>					ADDRESS <b>4001 Ritchie Hwy Balto Md</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1986</b>		
					REGISTRAR'S SIGNATURE <b>Julia Deaton-Rodner</b>				

BP



026962 DEC 15 86

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Richard Bernard Matthews</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 29, 1986</b>		2b. HOUR <b>1700p m</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-16-34</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United states</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Anne Arundel Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Groome</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>A.A. Co.</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>308 Loring Drive 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mc Kinley Matthews</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Brooks</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-28-7474</b>		17. INFORMANT ADDRESS <b>Bernadette Nicholson</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. Tacy Mourtzanakis</i>		DEGREE <b>M.D.</b> ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/4/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR TACY MOURTZANAKIS</b>		22e. ADDRESS <b>3400 Fort Meade Rd Laurel 20707</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-5-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial</b>	
24. FUNERAL DIRECTOR NAME <b>Hoffman Funeral Ser</b>		23d. LOCATION CITY OR TOWN <b>Landover P.G. Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>DEC 11 1986</b>	
23f. REGISTRAR'S SIGNATURE <i>Julia Sinden-Randall</i>		23g. ADDRESS <b>3605 14th St N.W. WASH. D.C.</b>			

2

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PATRICK Sean MCCANN</b>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI-MATED <input type="checkbox"/> <b>Dec. 4 19 86</b>		2b. HOUR <b>M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>27</b> YEAR <b>1981</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>5</b>	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	7c. DATE PRONOUNCED DEAD <b>Dec. 4 19 86</b>	7d. HOUR <b>9:09p</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>MD</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>105 Ralph Rd. 21061</b>	
14. FATHER'S NAME FIRST <b>Patrick</b> MIDDLE <b>Michael</b> LAST <b>Francis McCann</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ruby</b> MIDDLE <b>Mae</b> LAST <b>Brown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214.98.7058</b>		17. INFORMANT (mother) <b>Ruby McCann</b> ADDRESS <b>105 Ralph Rd. Glen Burnie Md. 21061</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. <b>8PM</b> MONTH <b>12</b> DAY <b>4</b> YEAR <b>1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by an auto</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hwy.</b>		21f. LOCATION STREET <b>Rt. #2 North of Morley Station Rd.</b> CITY <b>Anne Arundel</b> COUNTY <b>Co., Maryland</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>12-5-86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 6, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN <b>Elkridge</b> COUNTY <b>Howard</b> STATE <b>Md</b>	
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b> ADDRESS <b>Glen Burnie Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

100% COTTON FIBER

AND WINTER



028736 DEC 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anna Leyh McCreery</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 27 86</b>		2b. HOUR <b>1845</b> M	
3. SEX <b>Female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH DAY MONTH YEAR <b>Oct 13 1908</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AA Co.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>17 Elm Dr. 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George C. Leyh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah (UNKNOWN)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218/09/5326D</b>		17. INFORMANT ADDRESS <b>JoAnn K. Welsh (daughter) same as 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 few days</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Pneumonia, Paget's disease of bone</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>4/12</b> 19 <b>86</b> to <b>12/27</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>R. I. Hochman, MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/29/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. I. Hochman, MD</b>		22e. ADDRESS <b>16 Murray Ave, Annapolis, Md 21404</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 30, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn AA MD</b>
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, MD</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Benson-Rodarte</b>

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST KEVIN M. MCKEWEN				2a. DATE OF DEATH MONTH DAY YEAR 12 10 86				2b. HOUR 9 <sup>20</sup> A.M.			
3. SEX MALE		4. RACE C 1		5. DATE OF BIRTH MONTH DAY YEAR 4-15-54		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General (patient)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (patient)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY A. Arundel		13c. CITY OR TOWN Severna Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 159 Downing Dr. 21146					
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Donald McKewen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martina Hufnagel Smith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-68-2387		17. INFORMANT ADDRESS Mr. Thomas D. McKewen - Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>renal failure, pneumonia, retinopathy</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from <u>11-25</u> , 19 <u>86</u> , to <u>12-10</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>12-9</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>G.H. Mitchell MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12-16-86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G.H. Mitchell MD</u>				22e. ADDRESS <u>205 Ridge Ave Annapolis Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12-10-86		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR DEC 12 1986					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marquerite Violet Meyers			2a. DATE OF DEATH MONTH DAY YEAR Dec. 4 1986			2b. HOUR 9:45 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR NOV. 13 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Linthicum		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6100 Medora Road, Linthicum MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse (ret)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. CITY OR TOWN Anne Arundel		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 6100 Medora Road 21090		
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Smallwood			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bettie Royston						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT (friend) ADDRESS Mr. Richard Halckenberg 302 Sixth Ave Baltimore Md 21225					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 26</u> , 19 <u>85</u> , to <u>Dec 4</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Nov 21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. Milton Linthicum</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/4/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Milton C. Linthicum				22e. ADDRESS 202 W. Maple Road Linthicum Heights, Maryland 21090					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Dec. 6, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greencastle Franklyn Pa.			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home				ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 9 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Tidwell-Randall</u>	

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027127 DEC 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Aaron

Scott

Miller

3. SEX  
MALE4. RACE  
WHITE5. DATE OF BIRTH  
MONTH DAY YEAR  
8-14-19686. AGE (IN YEARS)  
LAST BIRTHDAY  
18 YRS.7. IF UNDER 1 YR.  
MONTHS DAYSIF UNDER 24 HRS.  
HOURS MIN2b. DATE KNOWN  
OF DEATH ESTI-  
MATED ☒ MONTH DAY YEAR  
12 5 19 862c. DATE  
PRONOUNCED  
DEAD MONTH DAY YEAR  
12 5 19 862d. HOUR  
7:05 PM7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Charlestown, W. Va. U.S.A.

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel County, MD.

10. CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Anne Arundel General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

service dispatcher automoti

12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Md.13b. COUNTY  
A.A.13c. CITY OR TOWN  
Shady Side13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒13e. STREET ADDRESS  
1657 Cedar Lane P.O. Box 2086714. FATHER'S NAME  
FIRST MIDDLE LAST

Paul

Miller Jr.

Carolyn

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST

Ann

118 Penwell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

232-94-9810

17. INFORMANT

ADDRESS

Carolyn A. Sweet same as 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR ☒ MONTH DAY YEAR  
6:45 P.M. 12 5 19 86

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

Driver in truck/vehicle impact

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

street

21f. LOCATION

Muddy Creek Rd.

CITY OR TOWN

COUNTY

A.A.

STATE

MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Therese Marie Yheler

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE  
SIGNED 12/6/86EXAMINER'S NAME  
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS 111 Penn St.

Balto. MD.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

12/9/86

23c. NAME OF CEMETERY OR CREMATORY

PLEASANT VIEW MEMORY MARTINSBURG, W. VA.

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

HARDESTY FUNERAL HOME ANNAPOLIS, MD.

ADDRESS 12 RIDGELY AVE.

25a. DATE REC'D. BY REGISTRAR

DEC 12 1986

25b. REGISTRAR'S SIGNATURE

M. A. Korell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHWH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0371871780



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **86 33548**  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (Last, first, middle initial) <b>Mabel Miller</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-16-86</b>			2b. HOUR <b>7:20A</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 10 37</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Louisiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Fort Meade</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kimbrough Army Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE <b>M.D.</b>			13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Fort Meade</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7735 A Nelson Ct. 20755</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wallace Cormier</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Mathews</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>563-64-1257</b>		17. INFORMANT ADDRESS <b>Willie Miller 7735 A Nelson Court, Fort Meade, MD</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Embolus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Valvular Heart Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>June 1986</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Mitral &amp; Tricuspid Valve</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> , 19 <b>86</b> , to <b>12-16</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>12-16</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we said (did not) see the body after death)							
22b. SIGNATURE <i>Raymond K. Nelson</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-16-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raymond K. Nelson M.D.</b>				22e. ADDRESS <b>Kimbrough Army Hospital, Fort Meade</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/20/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lafayette</b>	
24. FUNERAL DIRECTOR NAME <b>E. M. Dudley &amp; Sons Funeral Home</b> ADDRESS <b>3200 Rhode Island Ave., Mt. Rainier, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 22 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John R. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 & 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

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DEC 33 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon portion. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				86 33549	
1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM ROBERT MILLER, JR.			2a. DATE OF DEATH MONTH DAY YEAR December 22, 1986		2b. HOUR 6:36 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4/17/1928	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 311 West Riverview Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Earl M. Jorgenson Co.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY A. A.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 311 W. Riverview Rd 21225	
14. FATHER'S NAME FIRST MIDDLE LAST William Robert Miller, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Anna Gelzer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2	17. INFORMANT ADDRESS Anna M. Miller Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral &amp; Lung &amp; 7 lon of nodules</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 months</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1970</u> , 19 <u>  </u> , to <u>19 Dec</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>19 Dec</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Andrew R. Sosnowski MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/22/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Andrew R. Sosnowski, MD		22e. ADDRESS 4016 Ritchie Hwy., Baltimore, Md. 212			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/24/86	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, A.A. Co., Md.	25	
24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto.		237 E. Patapsco Ave. ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 23 1986	25b. REGISTRAR'S SIGNATURE <u>Julia Swickard-Pandora</u>

BP

050 34 18

027202 DEC 16 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>LEONARD</b> <b>RAYMOND</b> <b>MOLDZYK</b>					2a. DATE OF DEATH MONTH DAY YEAR HOUR PM <b>DECEMBER 13, 1986 505 PM</b>				
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 7 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) <b>NORTH ARLAND HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bartender</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>Glen Burnie</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1831 Ridgewick Road 21061</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank</b> <b>Moldzyk</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara</b> <b>Urbanowski</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II</b>		17. INFORMANT <b>Delva M. Moldzyk</b>		ADDRESS <b>Same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of left leg</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Severe Dehydration</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-29</b> 19 <b>86</b> , to <b>12-13</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>12-12</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Long S Hsu, MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <b>300 HOSPITAL DR SUITE 230</b>		MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-13-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LONG S HSU, MD</b>		22e. ADDRESS <b>GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/15/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto Md</b>			
24. FUNERAL DIRECTOR <b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>DEC 15 1986 Julia Dendron-Randall</b>				

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027959 DEC 13 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

3 3 5 5 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER P. MORGAN			2a. DATE OF DEATH MONTH DAY YEAR Dec. 14, 1986		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1914		
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. BIRTHPLACE STATE OR FOREIGN COUNTRY North Carolina		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8117 Edgewater Rd.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Burner		12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		13. STREET ADDRESS / ZIP CODE 8117 Edgewater Rd. (21226)		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Morgan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Petrie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
17. INFORMANT Margaret E. Morgan - Same as 13c		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: weeks months		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cerebral		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/6/81 to 2/18/86, that (I) (we) last saw the deceased alive on 11/18/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.						
22b. SIGNATURE Michael F. Garahy, M.D.		22c. DATE SIGNED Dec. 15, 1986		22d. ADDRESS 8651 Ft. Smallwood Dr., Pasadena, MD 21122		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk., A.A.Co., Maryland		24. FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hg., Baltimore, MD		25a. DATE REC'D. BY REGISTRAR DEC 19 1986		
25b. REGISTRAR'S SIGNATURE Julia Simon						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove covering. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 11 is marked, any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

10/1/1960

10/1/1960

10/1/1960

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10/1/1960

10/1/1960

10/1/1960

10/1/1960

10/1/1960

029465 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other remarkable event, the medical examiner must be notified at once.

STATE OF MARYLAND					DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.				
CERTIFICATE OF DEATH														
1. DECEASED NAME (TYPE OR PRINT) <b>BERTIE Elizabeth MORGAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12 30 86</b>					2b. HOUR <b>6 45 P.M.</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 01 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>71</b>		IF UNDER 24 HRS. HOURS MIN. <b>45</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.								
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner-Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Edgewater</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3311 Pochantas Drive 21037</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward D. Smith</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Kraus</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>214-05-2360</b>		17. INFORMANT <b>Thomas D. Jocus-Edgewater, MD 21037</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MINUTES</b>				
DUE TO, OR AS A CONSEQUENCE OF (b) <b>GASTRIC CARCINOMA</b>										7 MONTHS				
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from <b>12/29</b> , 19 <b>86</b> , to <b>12/30</b> , 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>12/29/86</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.														
22b. SIGNATURE <b>Robert Scott Eden</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/30/86</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Scott Eden, MD</b>				22e. ADDRESS <b>703 Giddings Ave. Annapolis, MD 21401</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 5, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington VA</b>								
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel-Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>								

1. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed and a brief description of the results achieved. The second part of the report is a detailed account of the work done on each project. It includes a description of the objectives of the project, the methods used, and the results obtained. The third part of the report is a discussion of the results of the work and a comparison of the results with those obtained in previous years. The fourth part of the report is a list of the references used in the work.

2. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed and a brief description of the results achieved. The second part of the report is a detailed account of the work done on each project. It includes a description of the objectives of the project, the methods used, and the results obtained. The third part of the report is a discussion of the results of the work and a comparison of the results with those obtained in previous years. The fourth part of the report is a list of the references used in the work.

3. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed and a brief description of the results achieved. The second part of the report is a detailed account of the work done on each project. It includes a description of the objectives of the project, the methods used, and the results obtained. The third part of the report is a discussion of the results of the work and a comparison of the results with those obtained in previous years. The fourth part of the report is a list of the references used in the work.

26907 DEC 12 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 5 3

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Jerome Sheldon Morome			2a DATE OF DEATH MONTH DAY YEAR December 10, 1986			2b HOUR Approx. 4:00 P.M.					
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 1, 1937		6 AGE (IN YEARS LAST BIRTHDAY) 49 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.					
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b KIND OF BUSINESS OR INDUSTRY Restaurant			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Anne Arundel		13c CITY OR TOWN Glen Burnie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 8020 Cross Creek Dr. 21061		
14 FATHER'S NAME FIRST MIDDLE LAST Charles Morome			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Merle M. Turner			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA	
17 INFORMANT (Wife) Mary L. Morome			ADDRESS Same as #13								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2)					
21d. INJURY OCCURRED (WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT SCHOOL <input type="checkbox"/> AT RECREATION <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from <u>12/1/86</u> to <u>12/10/86</u> that (2) we last saw the deceased on <u>12/10/86</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did (did not) see the body after death.											
22b SIGNATURE <u>Stuart Bell</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <u>12/11/86</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Bell, M.D.			22e ADDRESS 3501 Saint Paul Street Baltimore, Maryland 21218								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 13, 1986			23c NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park			23d LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.		
24 FUNERAL DIRECTOR NAME <u>R. H. Dyckman</u> ADDRESS Singleton Funeral Home Glen Burnie, Maryland						25a DATE REC'D. BY REGISTRAR DEC 11 1986			25b REGISTRAR'S SIGNATURE <u>Julia T. ...</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



20% NOTION 100%



100% NOTION 100%



100% NOTION 100%

029136 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or either of the above, the medical examiner must be consulted.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE SARA MOUNTAIN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26, 1986		2b. HOUR 0905 M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 6 25 16	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? usa	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE ADDRESS) ANN ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE penna	13b. COUNTY bedford	13c. CITY OR TOWN everett	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 23 W 4th Ave, 15537 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Charles F. Beegle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Irene Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 191-09-8481		17. INFORMANT ADDRESS Everett, Pa, 15537 Mr. Albert E. Mountain 23 W 4th Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cerebral Haemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>History of Malignant Brain Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> , 19 <u>86</u> , to <u>12/26</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED 14/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALJIT S SAWHNEY		22e. ADDRESS GLEN BURNIE MD 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial 12-29-86		23b. DATE 12-29-86	23c. NAME OF CEMETERY OR CREMATORY Everett Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Everett bedford penna
24. FUNERAL DIRECTOR Augusta Dalla Valle		ADDRESS Everett, Pa, 15537		25a. DATE REC'D. BY REGISTRAR JAN 2 1987	25b. REGISTRAR'S SIGNATURE Julia Deaton-Randall

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)



025702 DEC 21 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33555

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) MARION S MUIRHEAD			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 27, 1986			2b. HOUR 1217 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 5, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- Foreman		12b. KIND OF BUSINESS OR INDUSTRY State Roads		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. CITY OR TOWN A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14 Harding Rd. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Marian S. Muirhead			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Barton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-16-3231		17. INFORMANT ADDRESS Elizabeth Muirhead same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis & Emphysema PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Fever & Dehydration.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 1 year 10 yrs		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that this hospital attended the deceased from 11/17, 1986, to 11/27, 1986, that (I/we) last saw the deceased alive on 11/27, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (did not view the body after death.)										
22b. SIGNATURE DEGREE CALVIN E. HILPMANN, M.D.					22c. DATE SIGNED 11/27/86.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 3001 S. HANOVER STREET BALTIMORE, MARYLAND 21230					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 28 Nov. 86		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. MD			
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD 21061					25a. DATE REC'D. BY REGISTRAR NOV 28 1986		25b. REGISTRAR'S SIGNATURE John Sanders-Pedraza			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

7/11 28 7/11 7/11

11/25/86

025959 DEC 3

Item # 16b, Film G 622 12/9/86 I.J.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33556

1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
WILLIAM Fenner MUNSON		Male		White		August 23, 1907		79 YRS.		Maryland		U.S.A.				ANNE ARUNDEL COUNTY MD.		Ship Joiner		Civil Service	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Maryland		Anne Arundel		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		202 Oak Lane, N.W.		21061							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Robert		Fannie		No		217-58-1222		Dorothy L. Munson		Wife		Same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADULT Resp. Toy Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypotension shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Carcinoma of the Colon</u>																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/25</u> , 19 <u>86</u> , to <u>11/30</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>Glenn E. Robbins</u>		DEGREE		22c. DATE SIGNED																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED																	
GLENN E. ROBBINS, M.D.		1404 CRAIN HIGHWAY, SUITE 300 GLEN BURNIE, MARYLAND, 21061		Dec. 1, 1986																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE															
Burial		Dec. 4, 1986		Cedar Hill Cemetery		Brooklyn Anne Arundel Md															
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. RECEIVED BY REGISTER		25b. REGISTRAR'S SIGNATURE															
Singleton Funeral Home, Glen Burnie, Md.				DEC 2 1986		Julia Darden-Randall															

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

WILLIAM H. JAMES

CHEN, B. 2000.

1404 CHAIN HIGHWAY, SUITE 200

GLENN BURNETT, WACOTA, TEXAS

GILBERT F. ROBBINS, Ph.D.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	EST		
ELEANOR Dorothy MUSK			DECEMBER 12 1986			.602 PM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE		7. UNDER 1 YEAR
Female		White	July 15 1920			66		MONTHS
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ANNE ARUNDEL COUNTY MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE			NORTH ARUNDEL HOSPITAL			Secretary		State of Md.
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE	
Maryland			Anne Arundel		Glen Burnie		221 Kuethe Road 21061	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. ADDRESS		
John HENEROTY			UNKNOWN			495 Kenora Drive		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES?			18b. SOCIAL SECURITY NO.		17. INFORMANT			
No			None		Henry A. Musk, III (son)			
18c. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) Cardio-pulmonary arrest					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) metastatic mixed mesodermal tumor of the uterus					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED		
(P. EITHER, NOTIFY MEDICAL EXAMINER)			HOUR A.M. MONTH DAY YEAR			ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2		
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/11/86 to 12/12/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
IRA R. HOROWITZ			MD			Dec. 14, 1986		
22d. PHYSICIAN'S NAME			22e. ADDRESS					
(TYPE OR PRINT)			600 W. WOLFE DEPT GYN OB, BALTO MD 21205					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
(SPECIFY)			Dec. 16, 1986		Meadowridge Mem'l Park		CITY OR TOWN COUNTY STATE	
Burial					Elkridge		Howard Md.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
SINGLETON FUNERAL HOME, GLEN BURNIE, MARYLAND			DEC 16 1986			Dorinda R. Rader		

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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INVESTIGATION OF 1963

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STATE OF ARIZONA

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

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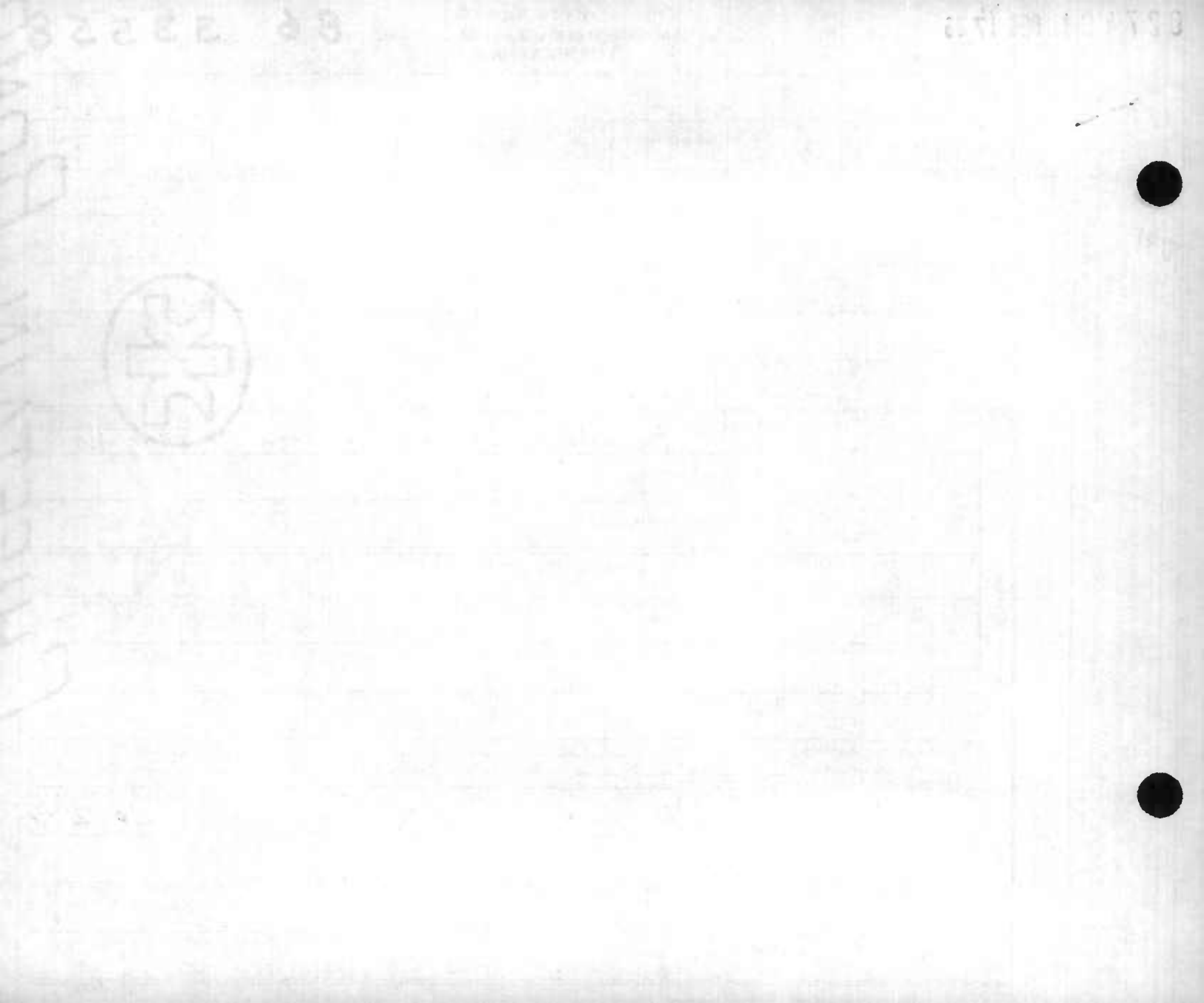
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Howard Clifton Nash			2a. DATE OF DEATH MONTH DAY YEAR December 11, 1986		2b. HOUR P M 7:00
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 19, 1941		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY MTA	
13a. STATE Maryland			13b. COUNTY A A Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert Nash			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beryl Nupp		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1958-1964		17. INFORMANT (Wife) ADDRESS Mrs. Veda M. Nash Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Oat Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Marshall A. Levine</u>				22c. DATE SIGNED <u>12/8/12/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marshall Levine, M.D.				22e. ADDRESS 711 West Fortieth Street Baltimore, Maryland 21211	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec 15, 1986	23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, AA Co. Md.		
24. FUNERAL DIRECTOR NAME H. J. Hopkins Singleton Funeral Home			25a. DATE REC'D. BY REGISTRAR DEC 16 1986		
ADDRESS Glen Burnie, Maryland			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

BP

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33559

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY A NAYLOR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 19 86</b>			2b. HOUR <b>0810 M</b>				
3. SEX <b>F</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 14 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1908 A Copeland Street 21401</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EUGENE TILLMAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHARLOTTE BROWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Severn, Md. 21144</b> <b>SHARON ABRAMS 1671 Independence Ct.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respirant</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GI Bleed</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ca Pancer</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <b>12-15 1986</b> to <b>12-19 86</b> , that (we) lost saw the deceased alive on <b>12-19 86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.										
22b. SIGNATURE <b>Michael J. LaPenta MD</b>			DEGREE			22c. DATE SIGNED <b>12/19/86</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL J. LAPENTA MD</b>			22e. ADDRESS <b>703 GIDDINGS AVE ANNA Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12-23-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILL CREST CEMETERY</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1986</b>				
						25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33560

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ESTELLE LEE NILES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 30 86</b>			2b. HOUR <b>1:30</b> <sup>a</sup>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 15 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>CROFTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CROFTON CONVALESCENT CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKER</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>CROFTON</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13e. STREET ADDRESS, ZIP CODE <b>21114 2131 Davidsonville Road</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE L. BROOKS</b>					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OLIVE L. WHITTAKER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> 16b. SOCIAL SECURITY NO. <b>215 07 5409</b> 17. INFORMATION <b>Glen Burnie, Maryland 21061</b> <b>Lawson B. Brooks 308 W. Furnace Branch Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>End stage Alzheimer's disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebrovascular insufficiency</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>Dec 4</u> , 19 <u>86</u> , to <u>Dec 30</u> , 19 <u>86</u> that (we) lost saw the deceased alive on <u>Dec 30</u> , 19 <u>86</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.							
22b. SIGNATURE <u>Potts &amp; Hung</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Dec 30 '86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Potts &amp; Hung</u>		22e. ADDRESS <u>3450 Ft Meade Rd #207 Laurel MD 21077</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/2/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FARNHAM BAPTIST CHURCH CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FARNHAM RICHMOND Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Raymond C. Fink Glen Burnie, Md. 21061</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1986</b>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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UNIT 1: Introduction

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026615 DEC 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 21. HOUR  
ESTIMATED ☐ 12 2 1986 M

1. DECEASED NAME FIRST MIDDLE LAST  
Elsie L. Nimrod

3. SEX F 4. RACE CAU 5. DATE OF BIRTH MONTH DAY YEAR 4 18 14 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

10. CITY OR TOWN OF DEATH Annapolis 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gov

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typeset 12b. KIND OF BUSINESS OR INDUSTRY US Gov

13a. STATE Md. 13b. CITY OR TOWN Churchton 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 5539 Carvel St.

14. FATHER'S NAME FIRST MIDDLE LAST Guy Soper 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN?) NO 16b. SOCIAL SECURITY NO. N/A 578 090688 17. INFORMANT Guy Nimrod

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

Hypertension

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE

William P. Jones, M.D.

TITLE (SPECIFY) Deputy

MEDICAL EXAMINER

DATE SIGNED

12/3/86

EXAMINER'S NAME (TYPE OR PRINT)

William P. Jones, M.D.

ADDRESS 695 America Crt., Davidsonville, Md. 21035

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

12-8-86

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN COUNTY STATE

Arlington National Arlington Va

24. FUNERAL DIRECTOR NAME

Roush, Corp

ADDRESS

Md. 20736

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

1 DEC 86 1986

John F. Smith, Registrar

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 FOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

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DHMH - 17  
(VR A15 ME (5))

05 221 128 50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BARBARA A. ODAU</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 02 86</b>		2b. HOUR MIN. <b>3:57 PM</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>06 23 34</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>52</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Wisconsin</b>		13b. COUNTY <b>Sheboygan</b>	13c. CITY OR TOWN <b>Kohler</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alex Rudolph</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ione Mueller</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Floyd Odau same address as #13</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gram Negative SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <del>XXXXXX</del> attended the deceased from <b>11/29</b> , 19 <b>86</b> , to <b>12/2</b> , 19 <b>86</b> , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on <b>12/2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) <del>XXXXXX</del> (did not) view the body after death.						
22b. SIGNATURE <b>Hector K. Collison M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/3/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HECTOR K. COLLISON M.D.</b>		22e. ADDRESS <b>125 OLD SOLOMONS FARM ROAD</b>				
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>Dec. 6, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		
23d. LOCATION CITY <b>Kohler, Wisconsin</b>		STATE <b>WISCONSIN</b>				
24. FUNERAL DIRECTOR NAME <b>Ives-Pearson Funeral Homes</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 08 1986</b>			
25b. REGISTRAR'S SIGNATURE <b>John J. Davidson</b>						

1. NAME		2. GRADE	
3. SEX		4. AGE	
5. DATE		6. TIME	
7. PLACE		8. REASON	
9. SIGNATURE		10. INITIALS	
11. ADDRESS		12. CITY	
13. STATE		14. ZIP	
15. PHONE		16. FAX	
17. E-MAIL		18. COMMENTS	
19. SIGNATURE		20. INITIALS	
21. ADDRESS		22. CITY	
23. STATE		24. ZIP	
25. PHONE		26. FAX	
27. E-MAIL		28. COMMENTS	
29. SIGNATURE		30. INITIALS	
31. ADDRESS		32. CITY	
33. STATE		34. ZIP	
35. PHONE		36. FAX	
37. E-MAIL		38. COMMENTS	
39. SIGNATURE		40. INITIALS	
41. ADDRESS		42. CITY	
43. STATE		44. ZIP	
45. PHONE		46. FAX	
47. E-MAIL		48. COMMENTS	
49. SIGNATURE		50. INITIALS	
51. ADDRESS		52. CITY	
53. STATE		54. ZIP	
55. PHONE		56. FAX	
57. E-MAIL		58. COMMENTS	
59. SIGNATURE		60. INITIALS	
61. ADDRESS		62. CITY	
63. STATE		64. ZIP	
65. PHONE		66. FAX	
67. E-MAIL		68. COMMENTS	
69. SIGNATURE		70. INITIALS	
71. ADDRESS		72. CITY	
73. STATE		74. ZIP	
75. PHONE		76. FAX	
77. E-MAIL		78. COMMENTS	
79. SIGNATURE		80. INITIALS	
81. ADDRESS		82. CITY	
83. STATE		84. ZIP	
85. PHONE		86. FAX	
87. E-MAIL		88. COMMENTS	
89. SIGNATURE		90. INITIALS	
91. ADDRESS		92. CITY	
93. STATE		94. ZIP	
95. PHONE		96. FAX	
97. E-MAIL		98. COMMENTS	
99. SIGNATURE		100. INITIALS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

028111 DEC

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PATRICK GERARD O'NEIL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DEC 21<sup>st</sup> 86</b>			2b. HOUR <b>16:10</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT 16<sup>th</sup> 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>2 months</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>2 5</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Edgewater</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1935 Shore Dr. 21037</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH L O'NEIL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VERONICA T BOLAND</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>MD</b>		17. INFORMANT ADDRESS <b>Joseph L. O'Neil Same as 13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGENITAL HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>TRISOMY 13.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>2 mos.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a. <b>NONE</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>16 OCT 19 86</b> , to <b>21 DEC 19 86</b> , that (I) (we) last saw the deceased alive on <b>16 DEC 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Proinnias</b>			DEGREE <b>M.B., B.Ch.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>21 DEC 86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PROINNIAS O' CROININ</b>			22e. ADDRESS <b>2981, SOLOMONS W. RD., EDGEWATER MD 21037</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/23/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Haven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silverspring Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>HARDESTY FUN. HOME</b>			ADDRESS <b>12 Ridgely Ann. Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 23 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Seaton-Rodgers</b>	

BP \_\_\_\_\_

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR									
Quaniece Lashonda Orange						12-2 1986						9:41 a.m.									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR							
Female		Black		12 25 84		1 YRS.						12-2 1986		9:41 a.m.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Germany				U.S.A.								Anne Arundel County, MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie				North Arundel Hospital																	
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland												A.A.		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Glen Burnie, Md 21061 8069 Green Orchard Road T4			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST						FIRST MIDDLE LAST															
Horace Orange						Jacqueline Murray															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						16c. FATHER'S ADDRESS									
No												Glen Burnie, Maryland 21061 T 4 Jacqueline Murray 8069 Green Orchard									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Blunt Trauma to Head																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?									
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
6:30xx 12-2 1986						subject was assaulted															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION									
Home						8069 Green Orchard Rd., Glen Burnie, Anne Arundel Co., Md.						Apt. T 4									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED									
Dennis F. Smyth, M.D.						Assistant						12-3-86									
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS															
Dennis F. Smyth, M.D.						111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial				12/6/86		Carroll Cemetery				Robertsville Jasper S C											
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Raymond e. Fink Glen Burnie, Md 21061												DEC 4 1986		Julia Jordan-Rudner							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

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(VR A15 ME (5))

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029462 JAN 1987

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert T M OVERSTREET, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 29 86</b>			2b. HOUR <b>5:45 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 26 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>		13a. USUAL RESIDENCE 13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2840 Carrollton Road</b>		13f. ZIP CODE <b>21403</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>David M. Overstreet</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mollie Williams</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>H95-36-5902</b>		17. INFORMANT ADDRESS <b>Same as #13</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarct</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Head Ather</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/25</b> , 19____, to <b>12/29</b> , 19____, that (I) (we) last saw the deceased alive on <b>12/28</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. Green</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/29</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Green, M.D.</b>				22e. ADDRESS <b>51 Franklin Street, Annapolis, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 31, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Anne's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>	
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>John Robert Paddy</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/28/1986</b>		2b. HOUR MIN. <b>7:32<sup>PM</sup></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9/02/1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>		
10. CITY OR TOWN OF DEATH <b>Friendship</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sonsbury Rd</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Friendship</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Sonsbury Rd 20758</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wallace Lee Paddy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Elizabeth Birkhead</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>	17. INFORMANT ADDRESS <b>Edna Paddy same CO #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (b). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>he had numerous ministrokes since</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>first onset 5/8/1984</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>right sided hemiplegia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>12/28/86</b> to <b>12/28/86</b> that (I) (we) last saw the deceased alive on <b>12/28/86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death, so state.)					
22b. SIGNATURE <b>C.H. Wirth M.D.</b>		DEGREE		22c. DATE SIGNED <b>12/29/86</b>	
22d. PHYSICIAN'S ADDRESS (TYPE OR PRINT) <b>C.H. Wirth, M.D.</b>		22e. ADDRESS <b>Lothian Md 20711</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>	23b. DATE <b>Dec 31 86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friendship</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Friendship AA MD</b>	
24. FUNERAL DIRECTOR NAME <b>Rauch Funeral Home Inc</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

MEDICAL CERTIFICATION

2000 Robert Brady

Male White 4/4-11-12

1981 10/10/81

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029296 JAN 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33561

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
EUA		J.		Parks				12 29 86					
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
F	CAU	5 16 36		50 YRS.						12 29 19 86		0955	
7a. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				AA							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel Gen		housewife		NA							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		AA		Deale		YES <input type="checkbox"/> NO <input type="checkbox"/>		5833 Rockhold Crk.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
James Lovelace		Gladys Brady											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		213 34 7914		Robert Parks		some co #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b). <u>A.S.C. V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c).												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Carcinoma breast</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
William P. Jones, M.D.		Deputy		12/29/86									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
William P. Jones, M.D.		695 America Crt Davidsonville, Md 21035											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		12-31-86		St James		Bethesda AA MD							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Kawach Funeral Home		A wings MD		DEC 31 1986		Julia Davidson-Pandora							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM W-3. RETURN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
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WILLIAM J. ...

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26514 DEC-9

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (FIRST, MIDDLE, LAST) <b>PAB Joseph Nelson PARKS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12/3/86</b>		2b. HOUR <b>10<sup>05</sup> A.M.</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 3 48</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>38</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CMDRIDGE, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>GAMBRILLS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>875 Claffy Rd. (HOME)</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LANDSCAPER</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>GAMBRILLS</b>	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>875 Claffy Rd. 21054</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MARTIN CARROLL PARKS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Christman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>X</b>		16b. SOCIAL SECURITY NO. <b>218-50-1896</b>		17. INFORMANT <b>BROTHER,</b> ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malabsorption Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acquired Immune Deficiency Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 mos.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) this hospital attended the deceased from <b>February 19 86</b> to <b>12/3 19 86</b> , that (2) (we) lost above, (we) did not give the body after death.		22b. SIGNATURE <b>Samuel Westrick MD</b> DEGREE	
22c. DATE SIGNED		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <b>3100 St. Paul Street, BALTIMORE, MD 21218</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>12/6/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dor. Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 8 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Fenton</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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028655 DEC 10 1986

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 363567	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul E. Paxton					2a. DATE OF DEATH MONTH DAY YEAR 12-20-86				2b. HOUR 3:20 PM		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5-22-17		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSP'T.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE CO.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY A. A. CO.		13c. CITY OR TOWN ARNOLD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 426 COLONIAL RIDGE LA. 21012			
14. FATHER'S NAME FIRST MIDDLE LAST JESSE E. PAXTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE HERMANN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 217-34-1842		17. INFORMANT EVELYN PAXTON		ADDRESS (SAME AS ITEM #13) (SAME AS ITEM #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) Metastatic Pancreatic Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 12/18 86 to 12/20 86, that (1) (we) saw the deceased alive on 12/20 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E.W. Cole III				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/20/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.W. COLE III				22e. ADDRESS 57 FRANKLIN ST. ANNAPOLIS Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-23-1986		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P.G.C. Md.					
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR DEC 29 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33570

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY Barnes PERLITZ			2a. DATE OF DEATH MONTH DAY YEAR 12 1 86			2b. HOUR #22 <sup>27</sup> PM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 13 96		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 134 Conduit Street 21401	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Anderson II				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Blackburn				16. ADDRESS Same as #13	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT William F. Perlitz - #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 12/1 1986 to 12/1 1986, that (1) (we) last saw the deceased alive on 12/1 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.									
22b. SIGNATURE E W Cole III					DEGREE MD		22c. DATE SIGNED 12/1/86		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III					22f. ADDRESS 51 FRANKLIN ST ANNAP. Md 21401				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 4, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD					25a. DATE REC'D. BY REGISTRAR DEC 3 1986		25b. REGISTRAR'S SIGNATURE Julia...		

BP

1. The first part of the document is a letter from the Director of the FBI to the Director of the CIA. The letter is dated 10/10/2009 and is addressed to the Director of the CIA. The letter is signed by the Director of the FBI and is titled "Re: [redacted]".

2. The second part of the document is a letter from the Director of the CIA to the Director of the FBI. The letter is dated 10/10/2009 and is addressed to the Director of the FBI. The letter is signed by the Director of the CIA and is titled "Re: [redacted]".

3. The third part of the document is a letter from the Director of the FBI to the Director of the CIA. The letter is dated 10/10/2009 and is addressed to the Director of the CIA. The letter is signed by the Director of the FBI and is titled "Re: [redacted]".

4. The fourth part of the document is a letter from the Director of the CIA to the Director of the FBI. The letter is dated 10/10/2009 and is addressed to the Director of the FBI. The letter is signed by the Director of the CIA and is titled "Re: [redacted]".

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5. The fifth part of the document is a letter from the Director of the FBI to the Director of the CIA. The letter is dated 10/10/2009 and is addressed to the Director of the CIA. The letter is signed by the Director of the FBI and is titled "Re: [redacted]".

6. The sixth part of the document is a letter from the Director of the CIA to the Director of the FBI. The letter is dated 10/10/2009 and is addressed to the Director of the FBI. The letter is signed by the Director of the CIA and is titled "Re: [redacted]".

7. The seventh part of the document is a letter from the Director of the FBI to the Director of the CIA. The letter is dated 10/10/2009 and is addressed to the Director of the CIA. The letter is signed by the Director of the FBI and is titled "Re: [redacted]".

8. The eighth part of the document is a letter from the Director of the CIA to the Director of the FBI. The letter is dated 10/10/2009 and is addressed to the Director of the FBI. The letter is signed by the Director of the CIA and is titled "Re: [redacted]".

9. The ninth part of the document is a letter from the Director of the FBI to the Director of the CIA. The letter is dated 10/10/2009 and is addressed to the Director of the CIA. The letter is signed by the Director of the FBI and is titled "Re: [redacted]".

10. The tenth part of the document is a letter from the Director of the CIA to the Director of the FBI. The letter is dated 10/10/2009 and is addressed to the Director of the FBI. The letter is signed by the Director of the CIA and is titled "Re: [redacted]".

027149 DEC 15

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 3 3 5 7 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph John Perzanowski			2a. DATE OF DEATH MONTH DAY YEAR 12-5-86		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Anne Arundel General Hosp.		12a. USUAL OCCUPATION (IF NOT WORKING FOR MOST OF WORKING LIFE) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY AACO.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1208 Locust La. 21037	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Perzanowski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Josephine Biedrycki		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 048093361		17. INFORMANT ADDRESS Anna s. Perzanowski Same as #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>2 years</u> <u>10 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 11/4</u> , 19 <u>85</u> , to <u>12/5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased on <u>12/5</u> , 19 <u>86</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Gregory S. Neilken</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory S. Neilken		22e. ADDRESS 134 Queenville Rd West River MD 20778			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-9-86	23c. NAME OF CEMETERY OR CREMATORY LAKEMONT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE DAVIDSONVILLE A.A. MD.
24. FUNERAL DIRECTOR HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN. MD.			25. DATE RECEIVED BY REGISTRAR 12/12/86 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The funeral director should remove carbon copies, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

1950

100% COTTON FIBER

MADE IN U.S.A.



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024491 NOV 1988

Item 18a, 22a, G-621, 11/22/88 STATE OF MARYLAND  
 FOR STATE by Med. Ex.,/Gb  
 REGISTRAR 12-1-86  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Stacey Elizabeth Pettis			2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 6 1986			2b. HOUR M 3:13A		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 20 1983		6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 6 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD		
10. CITY OR TOWN OF DEATH Fort Meade			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student (Child)			12b. KIND OF BUSINESS OR INDUSTRY Nurse School		
13a. STATE Maryland			13b. CITY OR TOWN Baltimore			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS Maryland 21144 7902 Citadel Drive, Severn		
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Pettis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brenda Eldridge			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.			16b. SOCIAL SECURITY NO.		
17. INFORMANT Alexander Pettis			ADDRESS Severn, Md. 21144 7902 Citadel Drive,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>congenital anomalies</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>William M. Zane</u>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 11/6/86		
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.			ADDRESS 111 Penn St. Balto.MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/10/1986			23c. NAME OF CEMETERY OR CREMATORY Pk. Maryland National Mem.			23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Maryland		
24. FUNERAL DIRECTOR NUMBER & SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216						25a. DATE REC'D. BY REGISTRAR NOV 17 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson Radner		

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICIL IN LINE 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MDHMH - 17  
(VR A15 ME (5))

024111103

Elizabeth

Female Black 2 20 1953

U. S. A. Maryland

Maryland Baltimore

Alexander Police

No.

Bridge Severn, Md. 21144  
Alexander Hotel 1903 Citadel Drive,  
Baltimore



2501 Gaynes Rd. Baltimore, Md. 21216  
KUTLER & SMITH FUNERAL HOME, INC.  
Baltimore  
Maryland

028912 JAN

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR	2b. HOUR
Wilbur A. Phelps					12-19 1986			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 24 HRS.	8. DATE PRONOUNCED DEAD	9. BALTIMORE CITY OR COUNTY OF DEATH	10. HOUR	
male	white	4 18 1926	60 YRS.	MONTHS DAYS HOURS MIN	12-19 1986	Anne Arundel County, MD	6:45 p.m.	
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		12. CITIZEN OF WHAT COUNTRY?		13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		14. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.				Anne Arundel County, MD		
15. CITY OR TOWN OF DEATH		16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		17. USUAL OCCUPATION (TYPE OF WORK OR LIFE)		18. KIND OF BUSINESS OR INDUSTRY		
Rivera Beach		beach near Harlem Road		Clerk				
19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		20. STATE		21. COUNTY		22. CITY		23. STREET ADDRESS
Maryland				Baltimore				1406 Meridene Dr. 21239
24. FATHER'S NAME		25. MOTHER'S MAIDEN NAME		26. SOCIAL SECURITY NO.		27. INFORMANT		28. ADDRESS
Wilbur G. Phelps		Rose E. Charch		220-18-9185		Evelyn K. Phelps		509 Castle Dr. 21212
29. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		30. (IF YES, GIVE YEAR OR DATES)		31. SOCIAL SECURITY NO.		32. INFORMANT		33. ADDRESS
yes		WW 11		220-18-9185		Evelyn K. Phelps		509 Castle Dr. 21212
34. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								35. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Drowning								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
Arteriosclerotic Cardiovascular Disease								
36. DATE OF OPERATION		37. CONDITION FOR WHICH OPERATION WAS PERFORMED?				38. AUTOPSY?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
39. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		40. TIME OF INJURY (est.)		41. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		42. LOCATION		
? P.M. 12-19 1986		subject found on beach						
43. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		44. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		45. CITY OR TOWN		46. COUNTY		47. STATE
beach		near Harlem Road, Rivera Beach, Anne Arundel						
48. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
49. ACTUAL SIGNATURE		50. TITLE (SPECIFY)		51. DATE SIGNED		52. REGISTRAR'S SIGNATURE		
William M. Zane		M.D. Assistant		12-20-86		A. H. Anderson-Pandora		
53. EXAMINER'S NAME (TYPE OR PRINT)		54. ADDRESS		55. DATE REC'D. BY REGISTRAR		56. REGISTRAR'S SIGNATURE		
William M. Zane, M.D.		111 Penn St., Balto., Md. 21201		DEC 30 1986		A. H. Anderson-Pandora		
57. BURIAL, CREMATION, REMOVAL (SPECIFY)		58. DATE		59. NAME OF CEMETERY OR CREMATORY		60. LOCATION		61. STATE
Burial		12/23/86		Woodlawn Cemetery		Woodlawn		Balto. Md.
62. FUNERAL DIRECTOR		63. NAME		64. ADDRESS		65. DATE REC'D. BY REGISTRAR		66. REGISTRAR'S SIGNATURE
Mitchell-Wiedefeld Home		6500 York Rd.				DEC 30 1986		A. H. Anderson-Pandora

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



026624 DEC 10 1986

Item 11 per phone 12/16/86 DAD  
FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 33574

1. DECEASED NAME (TYPE OR PRINT) Marie B. Plumer			2a. DATE OF DEATH 12 07 86			2b. HOUR 10 AM							
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 3 13 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel CO MD.							
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home-7868 Cedar Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY -				
13a. STATE MARYLAND			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Pasadena			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1868 Cedar Rd 2122	
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Caroline RHETTMAN										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-071410			17. INFORMANT Anne Marie Plumer 1868 Cedar Rd							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic Vagging</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) D.R.M. McLaughlin			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 80, to December 7 19 86, that (I) (we) lost saw the deceased alive on November 28 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jenny D. Skarbek M.D.			DEGREE For R.M. McLaughlin			22c. DATE SIGNED 12-07-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jenny D. SKARBET			22e. ADDRESS 3708 Mountain Rd Pasadena MD 21122										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 10, 1986			23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.				
24. FUNERAL DIRECTOR NAME LILLY & ZEILER, INC. 7005 CONKLING ST. 21224			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 9 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove colored pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

V

1029-370 JAN 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hazel Jeanette Purdue			2a. DATE OF DEATH MONTH DAY YEAR December 30, 1986		2b. HOUR 7:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 4, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer	12b. KIND OF BUSINESS OR INDUSTRY Penn Fruit Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY A A Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 128 South Bridge Dr. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Roy M. Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Weichert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA	17. INFORMANT (Sister) Mrs. Bertha E. Ziegler	ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>Cancer of Lung</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 16</u> 19 <u>86</u> to <u>Dec 30</u> 19 <u>86</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Dec 30</u> 19 <u>86</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jerry D. Skarbek</u>		DEGREE <u>MD</u>	22c. DATE SIGNED <u>12-31-86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerry D. Skarbek, M.D.		22e. ADDRESS 3708 Mountain Road Pasadena, Maryland 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Dec 31, 1986	23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.	23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.		
24. FUNERAL DIRECTOR NAME <u>R. H. Hyslop</u>		ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25. DATE REC'D. BY REGISTRAR JAN 6 1987	
		26. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examination will be notified and

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8633570			
1. DECEASED NAME (TYPE OR PRINT) <b>Shelton Queen</b>						2a. DATE OF DEATH MONTH <b>12</b> DAY <b>26</b> YEAR <b>86</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>17</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7b. HOUR <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL COUNTY</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>JANITOR</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>CROWNSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1629 Severn Chapel Road 21032</b>	
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE LAST <b>QUEEN</b>				15. MOTHER'S MAIDEN NAME FIRST <b>EMMA</b> MIDDLE <b>HALL</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Crownsville, Md. 21032</b> <b>MARTHA QUEEN 1629 Severn Chapel Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I/we) <input checked="" type="checkbox"/> saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James Chaconas</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>12/29/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Chaconas</b>				22e. ADDRESS <b>1521 Ritchie Hwy Arnold, Md 21012</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-31-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. TABOR CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>Annapolis</b> COUNTY <b>A.A.</b> STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b> NAME ADDRESS <b>Annapolis, Md. 21401</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1986</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Roads</b>					

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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

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029456 JAN 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 7 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Carrie D. Reese								Dec. 25, 1986				A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH DAY YEAR 6, 13, 1913		73 YRS		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Anne Arundel MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		401 Giddings Avenue		Clerk		Dry Cleaning							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MD		A.A.		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		401 Giddings Avenue		21401			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Joseph		Carrie		NO		619 1604 93A		Charles W. Reese, Sr.		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Dehydration - Malnutrition -		Severe, Terminal, longstanding Parkinsonism		7 years		3 mos							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		Sepsis from Urinary Tract											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. (Certify that (1) (this hospital) attended the deceased from 12/24/86 to 12/26/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.		1978		Present									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Peter Verkoewen				12/26/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
PETER F. VERKOWEN		1433 Forest Dr. Annapolis Md. 21401											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Cremation		Dec 26, 1986		Cedar Hill		Suitland PG. MD							
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Taylor Funeral Chapel - Annapolis, MD		JAN 5 1987		Julia Gordon-Randall									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked as item 18, the cause of death is the cause of death, or other traumatic event, the medical examiner must be notified at once.



026873 DEC 12 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

3 3 5 7 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marjorie B. Raleigh			2a. DATE OF DEATH MONTH DAY YEAR 12-10-86		2b. HOUR 3:40 A
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 29 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Edge water, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. STATE MD.	13b. COUNTY AA	13c. CITY OR TOWN EDGEWATER	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3918 River Chub Dr. 21037	
14. FATHER'S NAME FIRST MIDDLE LAST George Beall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Stewart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 559 147619	17. INFORMANT ROBERT RALEIGH		ADDRESS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast CA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-86					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-10-86, 19-86, to 12-10-86, 19-86, that (I) (we) last saw the deceased alive on 12-10-86, 19-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Jackson		DEGREE MD		22c. DATE SIGNED 12/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Jackson		22e. ADDRESS 1833 Forest Ave Annapolis, Md 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-12-86	23c. NAME OF CEMETERY OR CREMATORY HAKEMOUT CEMT	23d. LOCATION CITY OR TOWN COUNTY STATE DAVIDSONVILLE AA MD.		
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL		ADDRESS Annapolis, MD	25a. DATE REC'D. BY REGISTRAR DEC 11 1986	25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2, and place them in the envelope after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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1. The first part of the report is a summary of the work done during the year. It is divided into two main sections: a general summary and a detailed summary of the work done in each of the four quarters. The general summary is a brief overview of the work done, while the detailed summary provides a more in-depth look at the work done in each quarter.

2. The second part of the report is a detailed summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

3. The third part of the report is a summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

4. The fourth part of the report is a summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

5. The fifth part of the report is a summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

6. The sixth part of the report is a summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

7. The seventh part of the report is a summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

8. The eighth part of the report is a summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

9. The ninth part of the report is a summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

10. The tenth part of the report is a summary of the work done in each of the four quarters. This section is divided into four sub-sections, one for each quarter. Each sub-section provides a detailed account of the work done, including the objectives, the methods used, the results obtained, and the conclusions drawn.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WESLEY RANDALL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12/29/85</b>		2b. HOUR <b>11:52A</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 12 10</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LVA H</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE <b>2401 Callow Ave. 21217</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wesley Randall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Hardesty</b>		16. SOCIAL SECURITY NO. <b>216-03-3849</b>	
17. INFORMANT ADDRESS <b>Ruth E. Smith 2401 Callow Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alcoholic liver disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Stage D prostate cancer</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>2 years</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Boyd A. Owyer MD</b>	
22c. DATE SIGNED <b>12/29/86</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Boyd A. Owyer MD</b>		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/2/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat. Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		24. FUNERAL DIRECTOR NAME <b>W.C. March F.H. 4300 Wabash Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Benson-Randall</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical investigation must be completed.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Morgan Rensburg</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/27/86</b>		2b. HOUR <b>7:30</b> <sup>a</sup>				
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 27 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>surveyor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>wash. Gas \$ L</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Rose Haven</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Boston Ave. 20714</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Rensburg</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Bussey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 578 05 6762</b>		17. INFORMANT ADDRESS <b>Margaret Rensburg same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>S/p Resection of Ca of Thyrms</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo - 12 yrs -</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (Physician) attended the deceased from <b>July 1 1986</b> to <b>Dec. 27 1986</b> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Dec. 26 1986</b> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Gary M. Richardson, M.D.</b>					DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>12-29-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY M. RICHARDSON, M.D.</b>					22e. ADDRESS <b>104 Forbes Street, Annapolis, MD 21404</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>Dec 30, 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood PG MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Kanouch Funeral Home Owings MD</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frances Cralle Roberts</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 17, 1986</b>		2b. HOUR <b>7:30 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 20, 1918</b>		
6. AGE (IN YEARS (LAST BIRTHDAY)) <b>68 YRS</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNA ARUNDEL</b> MD.				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Anne Arun Edgewater</b>				
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS / ZIP CODE <b>1925 Ridgeville Road 21037</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard P Cralle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Audrey Bennett</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-34-7688</b>		17. INFORMANT ADDRESS <b>Chester Bennett Roberts Same as #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SLE; VENTRICULAR ANEURYSM; COPD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5-85</b> <b>5-85</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>SLE; VENTRICULAR ANEURYSM; COPD</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/15/85</b> , 19 <b>86</b> , to <b>12/17</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12/17</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Mary L. Michels</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/18/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARY L. MICHELSON MD.</b>		22e. ADDRESS <b>51 FRANKLIN STREET #420 ANNAPOLIS, MARYLAND 21401</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>22Dec1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert E Wilhelm Suitland, Md</b>				
25a. DATE REC'D. BY REGISTRAR <b>DEC 24 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, an and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Mildred S. Rosenthal</b>										2b. DATE OF DEATH MONTH DAY YEAR <b>12-27-86</b>		2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 - 13 - 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>							
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Annapolis Convalescent Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeping</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Glass Co.</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A. A.</b>		13c. CITY OR TOWN <b>Arnold</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>472 Century Vista Dr./21012</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Currie Lee Scrimger</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Gephart</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-10-8792A</b>		17. INFORMANT ADDRESS <b>Jean Pirkle (Same as # 13)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>29 Dec 1986</b> , that (I) (we) lost saw the deceased alive on <b>19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Jon Lowe</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>29/12/86</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Jon Lowe</b>				22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12 - 30 -86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, MD</b>					
24. FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANCO</b> ADDRESS <b>SEVERNA PARK, MD. 21146</b>						25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 02 1987</b>							

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OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301-1000

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*[Faint, mostly illegible text covering the majority of the page, appearing to be a memorandum or report.]*

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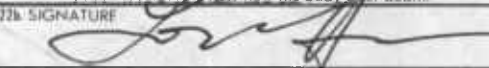
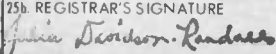
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in one of the following ways:

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		EST		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ADELINE (NMN) SANZONE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER, 11, 1986</b>			2b. HOUR <b>420 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 23, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A A Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6 Forest Street 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>(Unknown) Pusateri</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(Unknown)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NA</b>		17. INFORMANT (Son) <b>Patrick J. Sanzone</b>		ADDRESS <b>Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Metastatic Breast Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-22</b> , 19 <b>86</b> , to <b>12-11</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12-10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-11-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LONG S. HSU, M.D.</b>				22e. ADDRESS <b>300 HOSPITAL DR, SUITE 230 GLEN BURNIE, MARYLAND 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 15, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Park A A Co. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>R. A. [Signature]</b> ADDRESS <b>Singleton Funeral Home Glen Burnie, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 16 1986</b>		25b. REGISTRAR'S SIGNATURE 			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles E. Satchell			2a. DATE OF DEATH MONTH DAY YEAR 12 10 86			2b. HOUR 12:30 P.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 30 12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker		12b. KIND OF BUSINESS OR INDUSTRY Marina	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Satchell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Klutetz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 913 05 6239		17. INFORMANT ADDRESS Bretchen I Satchell #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH m/s
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-10-86 to 12-10-86, that (I) (we) last saw the deceased alive on 12-9-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE GAMitchell		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-10-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GAMitchell		22e. ADDRESS 205 Ridgely Ave Annapolis MD 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-86		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cent		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD.	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel		ADDRESS Annapolis Md		25a. DATE REC'D. BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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BP



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DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED ELIZABETH SCHMIDT</b>		7a. DATE OF DEATH MONTH <b>DECEMBER</b> DAY <b>25</b> , YEAR <b>1986</b> 7b. HOUR <b>739</b> AM <b>M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>26</b> YEAR <b>08</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail Sorter</b>
12b. KIND OF BUSINESS OR INDUSTRY <b>Postal Service</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE <b>Maryland</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Pasadena</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE <b>8136 Bodkin Avenue 21122</b>			
14. FATHER'S NAME FIRST <b>Jacob</b> MIDDLE LAST <b>Knipp</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lillie</b> MIDDLE LAST <b>Waring</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-01-9800</b>	
17. INFORMANT ADDRESS <b>Carl R. Schmidt, Jr. 353 Cooke St. 21001</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Perforated Ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/16/86</b> to <b>12/25/86</b> , that (I) (we) last saw the deceased alive on <b>12/24/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Chackumkal V. Cyriac, MD</b> DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/25/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHACKUMKAL V CYRIAC, MD</b>		22e. ADDRESS <b>14 WILLIAM AVE., SUITE 101 GLEN BURNIE, MARYLAND 21061</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/29/86</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b> ADDRESS <b>21229</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 29 1986</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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PLAZA - 300000

AND ARCADE COURT

CLUB HOUSE NORTH ARCADE HOSPITAL



CLUB HOUSE, PARKLAND 21001  
14 MILLMAN AVE, SUITE 101

CLUB HOUSE & CLINIC, MD

DEC 20 1990

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 3 5 8 5	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Margaret E. Schuiling</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 29 86</b>			2b. HOUR <b>8:30AM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 17 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>401 Irene Drive (Home)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home Maker</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>401 Irene Drive 21061</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul Upaul</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Yuhas</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>153-18-0862</b>		17. INFORMANT ADDRESS <b>John W. Schuiling Same as 13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular disease with CVA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic obstructive pulmonary disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Rheumatic heart disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/12</b> 19 <b>86</b> , to <b>12/29</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11/24</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Anthony J. Krueger</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>12/29/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. M. KRUEGER M.D.</b>						22e. ADDRESS <b>606 HAMMONDS LANE BALTO MD. 21225</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>			23b. DATE <b>1/2/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md</b>			
24. FUNERAL DIRECTOR <b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1986</b>					
						25b. REGISTRAR'S SIGNATURE <b>Julia Swenson-Rand</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

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and Animal County

A.A.

Annals

101 Lane Ave (Home)

Housewife

Annals

101 Lane Ave 2101

12

Annals

A.A.

Annals

Annals

Elizabeth

Annals

Annals

123-1-1962 John . . . . .

Annals 123-1-1962 John . . . . .

DEC 31 1962

Annals 123-1-1962 John . . . . .

028450 DEC 30 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 86 33581									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DONALD		Francis		SCOTT				12-23-86		11 <sup>00</sup> PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		07 - 22 - 1931		55 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		United States				Anne Arundel Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel General Hospital						Social Worker		Hospital	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Md.			A.A.		Annapolis				989 St. Margarets Dr./21401		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Walter F. Scott				Blanche Wilfong							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
Yes				Korea		219-28-0933 Mrs. Betty M. Scott (same as 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OF PANCREATIC CARCINOMA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/9/86</u> , 19 <u>86</u> , to <u>12/23/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/23/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Stanley Watkins</u>						DEGREE <u>ATTENDING PHYSICIAN</u> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/23/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Dr. Stanley Watkins M.D.						51 Franklin St. Annapolis Md. 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12-27-86		Md. Vet. Crownsville		Crownsville A.A. Mo.					
24. FUNERAL DIRECTOR NAME <u>ROBERT S. BARRANCO</u>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SEVERNA PARK, MD. 21144						DEC 29 1986		<u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

THOMAS J. GARDNER

SEYERNA PARK, MD. 21146  
ROBERT S. GARRARD

DEC 29 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		8 6 3 3 3 8 8					
1. DECEASED NAME (TYPE OR PRINT) Rebecca DENNIS Shaw				2a. DATE OF DEATH MONTH DAY YEAR Dec 21 1986		2b. HOUR P M			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR May 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 46 Fleet St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY Adm.	
13a. STATE md		13b. CITY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 46 Fleet St 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Charles DENNIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary JANE Actwood					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 075-18-8870		17. INFORMANT ADDRESS Drive Delores Queen 1212 Bayhighland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic obstructive pulmonary disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from July 1985, to 12/20, 1986, that (b) we lost saw the deceased alive on Nov 1986, and that (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) we (did) (did not) view the body after death									
22b. SIGNATURE Gregory S. Neilley MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory S. Neilley MD				22e. ADDRESS 134 Owensville Rd West River MD 20718					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest mem.		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. md			
24. FUNERAL DIRECTOR NAME C. E. Hicks III				ADDRESS 1922 Forest Drive		25a. DATE REC'D. BY REGISTRAR DEC 29 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. MONTH DAY YEAR			4b. HOUR		
George Joseph Shepeta			DEC 27/19 86			8:51 P					
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			8. DEATH		
MALE	WHITE	JUNE 21, 1925	61 YRS.			DECEMBER 27, 1986					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY 51 DEATH		
PENNSYLVANIA			U.S.A.			Anne Arundel County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			North Arundel Hospital			DISABLE VET.			NONE		
13a. STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MARYLAND			ANNE ARUNDEL			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1021 FITZALLEN ROAD 21061		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
JOHN			CHRISTINA KRUPIZA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			200.20.0478		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
HENRY SHEPETA (BROTHER)			PART 1 DEATH WAS CAUSED BY:			SAME AS 13					
			IMMEDIATE CAUSE (a) Multiple Injuries								
			DUE TO, OR AS A CONSEQUENCE OF								
			(b) DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			7:35 P.M. 12/ 27/19 86			subject pedestrian struck by auto					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
			roadway			Rt. #2 & Fitzallen Rd., Glen Burnie, Md.					
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE			TITLE (SPECIFY)						DATE SIGNED		
Dennis F. Smyth, M.D.			Assistant MEDICAL EXAMINER						12/28/86		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
Dennis F. Smyth, M.D.			111 Penn St.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
BURIAL			DEC. 31, 1986			MARYLAND VETERANS CEM.			CROWNSVILLE A.A. MD.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE		
SINGLETON FUNERAL HOME, GLEN BURNIE, MD.			DEC 30 1986								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 3 3 5 9 0  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SKILES MYRTLE E. SKILES			2a. DATE OF DEATH MONTH DAY YEAR 12-25-86			2b. HOUR 5:00 PM	
3. SEX 207 FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 07 19 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. ARUNDEL CONVALESCENT		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY TALBOT	13c. CITY OR TOWN WITMAN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 124 21676	
14. FATHER'S NAME FIRST MIDDLE LAST RUDOLPH BETOWSKY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH KRAUTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-9077		17. INFORMANT ADDRESS THOMAS E. MADDEN (SAME AS 13A-E)			

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiac asystole

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) aged, ASCV

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

suspected carcinoma of lung

19a. DATE OF OPERATION <u>December 5, 1986</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>lung</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>December 5, 1986</u> to <u>December 25, 1986</u> , that (I) (we) last saw the deceased alive on <u>December 25, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Jerry D. Skanbeck</u>		22c. DATE SIGNED 12-25-86		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jerry D. Skanbeck</u>		22f. ADDRESS <u>3708 Mountain Rd Pasadena Md. 21122</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DEC. 29, 1986	23c. NAME OF CEMETERY OR CREMATORY MT OLIVETT CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MD
24. FUNERAL DIRECTOR NAME McCully Funeral Homes		25a. DATE REC'D. BY REGISTRAR DEC 30 1986	25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

1 DECEASED NAME (TYPE OR PRINT) <b>CHARLES HURBERT SLATER, SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 04, 1986</b>			2b. HOUR <b>1021 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 26, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>53 YRS.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10 CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Local #24</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>A A Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Slater</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion Leon</b>			13e. STREET ADDRESS / ZIP CODE <b>21061 7856 Americana Circle Apt T2</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NA 213.30.0079</b>		17 INFORMANT (Son) ADDRESS <b>Charles H. Slater, Jr./Glen Burnie, Md. 21061</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>with coarctation of aorta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>with coarctation of aorta</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>325 HOSPITAL DRIVE, SUITE 104 GLEN BURNIE, MD. 21061</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/2/86</b> to <b>12/4/86</b> , that (I) (we) last saw the deceased alive on <b>12/4/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Recep Erol</b>			DEGREE			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RECEP EROL, M.D.</b>			22e. ADDRESS <b>325 HOSPITAL DRIVE, SUITE 104 GLEN BURNIE, MD. 21061</b>			22f. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec 8, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A A Co. Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b>			ADDRESS <b>Glen Burnie, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

10 01 281 S

PO BOX 1000  
JAN 10 1960



027641 DEC 10 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ALVIN

LAMAR

SMITH

2a. DATE KNOWN  
OF DEATH ESTI-  
MATED

MONTH DAY YEAR

7b. HOUR

12 10 1986

5 P M

3. SEX

male

4. RACE

Caucasian

5. DATE OF BIRTH  
MONTH DAY YEAR

8-12-64

6. AGE (IN YEARS)  
LAST BIRTHDAY

22 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE  
PRONOUNCED  
DEAD

12-10-1986

2d. HOUR

2049 M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel

MD

10. CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Anne Arundel General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Logger/Carpentry

12b. KIND OF BUSINESS  
OR INDUSTRY

Private

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

md.

13b. COUNTY

A.A.

13c. CITY OR TOWN

DAVIDSONVILLE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1329 W. Central Ave

P. O. Box 115

21035

14. FATHER'S NAME

David

MIDDLE

G.

LAST

Smith

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

A.

LAST

Phillips

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

N/A

16. SOCIAL SECURITY NO.

220-94-1933

17. INFORMANT

ADDRESS

David G. Smith Same as 13 A-E

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ASPHYXIA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

HANGING

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MINUTE 765

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opiniondeath resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.ACTUAL  
SIGNATURE

Charles A. Seager

M.D.

TITLE (SPECIFY)  
DEPUTY

MEDICAL EXAMINER

DATE  
SIGNED

12/10/86

EXAMINER'S NAME  
(TYPE OR PRINT)

CHARLES A. SEAGER

ADDRESS

780 RITCHIE HWY. SU PK

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

12/13/86

23c. NAME OF CEMETERY OR CREMATORY

Lakemont Mem. Gardens

23d. LOCATION  
CITY OR TOWN

Davidsonville Anne Arundel Md

COUNTY

STATE

24. FUNERAL DIRECTOR

Lee Funeral Home Inc.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DEC 17 1986

Julia Davidson-Randall

6633 Old Alexander Ferry Rd Clinton, Md 20735

07/B4  
25M

BP

DHMH - 17

(VR A15 ME (5

027611003



026464 DEC-06

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Florence ELIZABETH Smith</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 2 86</i>			2b. HOUR <i>2:28 PM</i>	
3. SEX <i>F</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-06-1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>	
13a. STATE <i>MD.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>ISAAC JONES</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Georgie GREEN</i>		13e. STREET ADDRESS / ZIP CODE <i>130 O'Berry Court 21401</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-56-2086</i>		17. INFORMANT ADDRESS <i>Romaine Parker 130 O'Berry Court ANNAPOLIS</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Myocardial infarction, long time heart failure</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12 12 19 86</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>205 Ridgely Ave Annapolis MD</i>			
22a. I certify that (I [this hospital]) attended the deceased from <i>12/2/86</i> to <i>12/2/86</i> , that (I [we]) last saw the deceased above on <i>12/2/86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE <i>George C. Samaras</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/2/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>George C. Samaras</i>				22e. ADDRESS <i>205 Ridgely Ave Annapolis MD</i>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <i>BURIAL</i>		23b. DATE <i>Dec 8, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pine Lawn</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ANNAPOLIS A.A. MD</i>	
24. FUNERAL DIRECTOR NAME <i>C. G. Hicks</i>				ADDRESS <i>1922 Forest Drive</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 8 1986</i>	
				25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodgers</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner must be notified at once.

BP

2025

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*[Faint handwritten notes at the bottom of the page, possibly bleed-through from the reverse side.]*

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027146 Dec 15, 1986

Item 1, Per. F.H. 12/19/86 lab  
 FOR  
 1- STATE  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33594

1. DECEASED NAME (TYPE OR PRINT) <b>HARRY S. SMITHERS</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12-10 19 86</b>				2b. HOUR <b>4:30</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 5, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>12/10/86 19 11</b>		2d. HOUR <b>PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Calif.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>Odenton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>506 Gladhill Rd.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Odenton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>506 Gladhill Rd.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry A. Smithers</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan M. Winfrey</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>41-63</b>		17. INFORMANT <b>Audrey Smithers</b>				ADDRESS <b>same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION, DIABETES, TOBACCO ABUSE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>U.L. Seager MD</b>						TITLE (SPECIFY) <b>DEPUTY</b>				MEDICAL EXAMINER DATE SIGNED <b>12/16/86</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>CHARLES A. SEAGER</b>						ADDRESS <b>780 RITCHIE HWY, SU PK.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>12-13-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD. VETERANS CEM</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>CROWNSVILLE A.A. MD.</b>					
24. FUNERAL DIRECTOR NAME <b>HARDESTY FUNERAL HOME</b>						ADDRESS <b>12 RIDGELY AVE. ANN. MD. 21401</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 16 1986</b>				25b. REGISTRAR'S SIGNATURE <b>John Anderson</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
 (VR A15 ME (5))  
 15M 2/80

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

replacement Certificate

40208



12/1/60

12/1/60



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. The funeral director should remove the deceased's name from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 3 3 5 9 5	
FOR 1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola E Spigler					2a. DATE OF DEATH MONTH DAY YEAR 12-19-86			2b. HOUR 8:50 PM			
1. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR June 15 1889		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN Mont. Rockville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 4709 Glasgow Drive Rockville MD 20853					
14. FATHER'S NAME FIRST MIDDLE LAST Francis F. Borgman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wahi						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A					16b. SOCIAL SECURITY NO. 578-05-6492		17. INFORMANT ADDRESS 5708 Misty Drive Lanham, Md. Francis Spigler (Son)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
21f. I certify that (1) this hospital attended the deceased from 12/18 to 12/19, 1986, and that in my opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.)											
21g. SIGNATURE EW Cole						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/19/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III						22e. ADDRESS 51 FRANKLIN ST ANNAP. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/23/86		23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.			
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.						25a. DATE REC'D. BY REGISTRAR DEC 23 1986		25b. REGISTRAR'S SIGNATURE Julia Benson			

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027204 DEC 16 86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard H. Szymanski			2a. DATE OF DEATH MONTH DAY YEAR 12 12 86			2b. HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 17 22		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 931 Sunny Brook Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Soldier		12b. KIND OF BUSINESS OR INDUSTRY Military	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Szymanski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie C. Wozniowski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1943-1964		17. INFORMANT ADDRESS Elsalena V. Szymanski		Same as 13e	
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CENTRAL NERVOUS SYSTEM METASTASES</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CANCER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>86</u> to <u>Dec</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Mar. 12/9</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Edward James Britt</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD JAMES BRITT				22e. ADDRESS FRANCIS SCOTT KEY HAVEN BALTO MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/86		23c. NAME OF CEMETERY OR CREMATORY State Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR DEC 15 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or funeral. Then please return completed page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical and surgical history should be certified on this page.)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT) <b>MARTHA MARIE TAYLOR</b>						2a. DATE OF DEATH MONTH <b>DECEMBER</b> DAY <b>16</b> YEAR <b>1986</b>		2b. HOUR <b>1235 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>January</b> DAY <b>3</b> YEAR <b>1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 YRS.</b>		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
12. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>		16b. COUNTY <b>A A Co.</b>		16c. CITY OR TOWN <b>Seyern</b>		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE <b>1216 Seyern Road 21144</b>	
17. FATHER'S NAME FIRST <b>Louis</b> MIDDLE <b></b> LAST <b>Knopp</b>				18. MOTHER'S MAIDEN NAME FIRST <b>Agusta</b> MIDDLE <b></b> LAST <b>Kroll</b>					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		19b. SOCIAL SECURITY NO. <b>NA</b>		20. INFORMANT (Son) <b>Vernon Taylor</b>		21. ADDRESS <b>826 Cedarcroft Drive Millersville, Md. 21108</b>			
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Recent Myocardial Infarction</b>						<b>Hypertensive C.V. Disease</b>			
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED		23c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
25a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		25c. LOCATION STREET <b>12-18</b> CITY OR TOWN <b>12-16</b> COUNTY <b>5</b> STATE <b>5</b>					
26. I certify that (I) (this hospital) attended the deceased from <b>12-18</b> , 19 <b>86</b> , to <b>12-16</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>12-18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
27. SIGNATURE <b>Hilary T. O'Herlihy</b>		28. DEGREE <b>M.D.</b>		29. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		30. DATE SIGNED <b>12-17-86</b>			
31. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HILARY T. O'HERLIHY, M.D.</b>		32. ADDRESS <b>325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061</b>							
33a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		33b. DATE <b>Dec 19, 1986</b>		33c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		33d. LOCATION CITY OR TOWN <b>Glen Burnie</b> COUNTY <b>A A Co.</b> STATE <b>Md.</b>			
34. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b> ADDRESS <b>Glen Burnie, Maryland</b>				35. DATE REC'D. BY REGISTRAR <b>DEC 18 1986</b>		36. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			



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DIVISION OF VITAL RECORDS, 301 W. PEESTON ST., BALTIMORE, MD. 21201

FOR Med. Ex., 1/31/87 22a, G-623, 6y										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										3 3 5 9 8									
1- STATE REGISTRAR Gbj.										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH ESTIMATED									
Douglas Anthony Thennes																				<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR 12/ 21/ 86									
1. SEX										4. RACE										5. DATE OF BIRTH									
Male										White										Dec. 28, 1956 29 YRS. MONTH DAY YEAR LAST BIRTHDAY									
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
Maryland										United States										9. BALTIMORE CITY OR COUNTY OF DEATH									
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
Glen Burnie										North Arundel Hospital										Supervisor									
12b. KIND OF BUSINESS OR INDUSTRY										12c. DATE PRONOUNCED DEAD										24. HOUR									
Boat Sales										12/ 21/ 86										3:09 A M									
13a. STATE										13b. COUNTY										13c. CITY OR TOWN									
Maryland										Anne Arundel										Pasadena									
14. FATHER'S NAME (FIRST MIDDLE LAST)										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
Matthew Thennes										Irene Radke										261 Carvel Rd. 21122									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS									
No										216 70 4502										Rosemarie Thennes (Same as 13 a-e)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a) Multiple Drug Intoxication																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause first.										DUE TO, OR AS A CONSEQUENCE OF																			
										(b) DUE TO, OR AS A CONSEQUENCE OF																			
										(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> PRIMARY CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 12 21 1986										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home										21f. LOCATION STREET CITY OR TOWN STATE Maryland									
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home										21i. LOCATION STREET CITY OR TOWN STATE Maryland									
22a. I certify that I took charge of the remains described above, held on										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:										Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .									
ACTUAL SIGNATURE										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 12/21/86									
EXAMINER'S NAME (TYPE OR PRINT)										Gregory R. Kauffman, M.D.										ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY									
Cremation										Dec. 24, '86										Security Process, Inc.									
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
McCully Funeral Homes										3204 Mountain Rd. Pasadena, MD 21122										DEC 30 1986									

BP 427

DHMH - 17 (VR A15 ME (5))

07/84 25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PEESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

RECEIVED  
JAN 10 1964

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 5 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marilyn E. THORINGTON			2a. DATE OF DEATH MONTH DAY YEAR DEC 18 86			2b. HOUR P <sub>M</sub>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 30 1926		6. AGE, (IN YEARS LAST BIRTHDAY) 60 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 462 Hoppereng Trail		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Louis H. Jentz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann MacKewit		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 148-14-7025	
17. INFORMANT James Thorington -		ADDRESS Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart CA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>54y.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/15/86, 19 86, to 12/18/86, 19 86, that (I) (we) lost the deceased alive on 12/15/86, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard Colgan, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/19/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Colgan, MD		22e. ADDRESS 703 Giddings Ave, Annapolis, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/20/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		ADDRESS		25a. DATE OF SIGNATURE DEC 23 1986		25b. REGISTRAR'S SIGNATURE Julia Benson	

The following is a list of the  
 names of the persons who  
 were present at the meeting  
 held on the 1st day of  
 January, 1900.

The names of the persons who  
 were present at the meeting  
 held on the 1st day of  
 January, 1900.

The names of the persons who  
 were present at the meeting  
 held on the 1st day of  
 January, 1900.

The names of the persons who  
 were present at the meeting  
 held on the 1st day of  
 January, 1900.

026618 DEC 10 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) DOUGLAS HARRY TITUS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 04, 1986		2b. HOUR 11:00 PM						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 6, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Billing Clerk		12b. KIND OF BUSINESS OR INDUSTRY Martins Auto Parts			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY AA		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 184 Oak Drive 21122		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Otis Titus			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret M. Douglas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mitchell Titus, Same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intractable pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF <i>generalized arteriosclerosis</i> (b) <i>gangrene of foot</i> DUE TO, OR AS A CONSEQUENCE OF <i>old CVA</i> (c) <i>old CVA</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Status - post permanent pacemaker - 3/84.</i>											
19a. DATE OF OPERATION <i>N/A</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>N/A</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>N/A</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <i>Work</i>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Work</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 23, 1986</i> to <i>Dec. 4, 1986</i> , that (I) (we) last saw the deceased alive on <i>Dec. 4, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Benjamin A. de Guzman</i>			DEGREE <i>M.D.</i>			22c. DATE SIGNED <i>12/04/86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN A. DE GUZMAN, M.D.			22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 108 GLEN BURNIE, MARYLAND 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 8, 1986		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD				
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR DEC 9 1986		25b. REGISTRAR'S SIGNATURE <i>John Gordon-Rodgers</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card to pages 1 and 2 should be filed in the 272 form after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1011

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 6

3.3.001

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RITA PAULINE TITUS			2a. DATE OF DEATH MONTH DAY YEAR 12/20/86			2b. HOUR 7:30 P.M.			
3 SEX FEMALE		4 RACE CAUCSIAN		5. DATE OF BIRTH MONTH DAY YEAR 1 25 1896		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) San Diego, Calif.		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.			
10 CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 408 Old County Rd.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Mother	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 408 Old County Rd./21146	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Lopez				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loretta Pedrine Lopez					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO. 457-14-7370		17 INFORMANT ADDRESS Marqueritte Mills (same as above)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <u>March 2</u> , 19 <u>86</u> , to <u>December 22</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec 8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. C. Cullis MD</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. CULLIS M.D.					22e. ADDRESS 7 Riggs Ave., Severna Park, Md 21146				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-22-86		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION Annapolis A.A. COUNTY Md. STATE		
24 FUNERAL DIRECTOR NAME ROBERT S. BARRANCO SEVERNA PARK, MD. 21146					25a. DATE REC'D. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be retained by the funeral director. Page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as "I" (I) or "we" (we), the medical examiner must be notified.

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OF COLLEGE LIBS

REVEREND PARK RD. 21146  
ROBERT T. BARRACLOUGH

027092 DEC 15 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33602

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Eugenia D Toya			2a. DATE OF DEATH MONTH DAY YEAR 12/3/86			2b. HOUR 7:10 PM			
3. SEX Female		4. RACE Spanish		5. DATE OF BIRTH MONTH DAY YEAR 03 20 97		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spain		8b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Crofton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9813 Belhaven Rd 20817	
14. FATHER'S NAME FIRST MIA PETRONILO MIDDLE LAST PRADOS				15. MOTHER'S MAIDEN NAME FIRST MIA SEGUNDA MIDDLE LAST PEREZ					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-32-3048		17. INFORMANT ADDRESS MARINA BEASLEY DAVIDSONVILLE, MD.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>urinary tract infection and sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9/85</u> to <u>12/3/86</u> , that (I) (we) last saw the deceased alive on <u>12/3/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)									
22b. SIGNATURE <u>Pavi B. Beréz MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pavi B. Beréz MD		22e. ADDRESS Box 3491 1555 Cypress Blvd Crofton MD 21114							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/6/86		23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY		23d. LOCATION WESTERNPORT ALLEGANY MD. STATE			
24. FUNERAL DIRECTOR NAME BOAL FUNERAL SERVICE, P.A. ADDRESS WESTERNPORT, MD.				25a. DATE REC'D. BY REGISTRAR DEC 09 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Kudala			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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RECEIVED  
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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33603  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
AMELIA ELIZABETH TUCKER		DECEMBER 21, 1986		0953 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Female	White	1899 MONTH DAY YEAR September 25, 1989	87 97 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL	Homemaker	Own Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	A A Co.	Pasadena	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8491 Bussenius Road 21122	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
William	Mary	NO NA			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
212.03.7077	Pat Newton	227 11th Street Pasadena, Maryland 21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Myocardial Infarction					
DUE TO, OR AS A CONSEQUENCE OF (b) Liver Cancer					
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/85, 19, to 12/21/86, 19, that (I) (we) lost saw the deceased on 12/13/86, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
E. J. Th		M.D.		12/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DR. CARL T. FOLKEMER		4141 MOUNTAIN ROAD PASADENA, MD. 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Dec 24, 1986	Parkwood Cemetery	Parkville	Balto.	MD.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
R. A. Hopkins		DEC 23 1986		R. A. Hopkins	
24. FUNERAL HOME ADDRESS		25c. REGISTRAR'S SIGNATURE			
Singleton Funeral Home Glen Burnie, Maryland		R. A. Hopkins			

028224 DEC 29 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

MEDICAL CERTIFICATION

22003 66

22003 66

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126540 DEC - 86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33604

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DORIS Alma TURNER			2a. DATE OF DEATH MONTH DAY YEAR 12-3-86			2b. HOUR 1755			
3. SEX F		4. RACE C I		5. DATE OF BIRTH MONTH DAY YEAR 7-24-14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN) Maryland		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Accounting	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Dunkirk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Genoa Rd Fairhaven 20754	
14. FATHER'S NAME FIRST MIDDLE LAST Christopher C Leitch				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lois Plummer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS Nancy Skillman 6318 McKendree Rd Dunkirk Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Resp. Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CVA DUE TO, OR AS A CONSEQUENCE OF } (c) Atherosclerotic C-V disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days Chronic									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1983, to Dec 3, 1986, that (I) (we) last saw the deceased alive on Dec 3, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE Barry P. Nathanson MD					DEGREE MD		22c. DATE SIGNED 12/3/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY P. NATHANSON MD					22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 12 6 86		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lothian A.A. Maryland		
24. FUNERAL DIRECTOR Clausen					ADDRESS Clausen, Md. 20736		25. DATE REC'D. BY REGISTRAR DEC 8 1986		
							26. REGISTRAR'S SIGNATURE Julia Decker-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please detach carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

86 23604

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Handwritten notes and diagrams, including a large circular diagram with internal lines and text, and a smaller diagram below it. The text is mostly illegible due to fading.



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR STATE REGISTRAR

1. DECEASED NAME  
 (TYPE OR PRINT) **JAMES Ellsworth Turner**

2a. DATE KNOWN OF DEATH  
 ESTIMATED **12/10/86**

2b. HOUR **1300**

3. SEX **M**

4. RACE **CAU**

5. DATE OF BIRTH  
 MONTH DAY YEAR **12 27 20 65**

6. AGE (IN YEARS)  
 (LAST BIRTHDAY) **21**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Washington, D. C.**

7b. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

8. MARRIED ☐ NEVER MARRIED ☐  
 WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**Anne Arundel**

10. CITY OR TOWN OF DEATH  
**Shady Side**

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
 (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**4969 Elm St.**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Office Manager**

12b. KIND OF BUSINESS OR INDUSTRY  
**Office Supply**

13a. STATE  
**Md.**

13b. COUNTY  
**A.A.**

13c. CITY OR TOWN  
**Shady Side**

13d. INSIDE CITY LIMITS?  
 YES ☐ NO ☐

13e. STREET ADDRESS  
**4969 Elm St.**

14. FATHER'S NAME  
 FIRST MIDDLE LAST  
**James Earl Turner**

15. MOTHER'S MAIDEN NAME  
 FIRST MIDDLE LAST  
**Nettie Irene Padgett**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (YES, NO, OR UNKNOWN)  
**Yes**

16b. SOCIAL SECURITY NO.  
**534-24-3363**

17. INFORMANT  
**13106 Clarion Ct. H.R. Collins Ft. Washington, Md.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART 1 DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) **Cardiac Arrest.**  
 (b) **A.S.C. V.D.**  
 (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  
**Hypertension**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?  
 YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
 HOUR A.M. MONTH DAY YEAR  
 P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐  
 AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
 STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE **William P. Jones, MD** TITLE (SPECIFY) **Deputy** MEDICAL EXAMINER

EXAMINER'S NAME (TYPE OR PRINT) **William P. Jones, MD** ADDRESS **695 America Ct. 21035**

23a. BURIAL, CREMATION, REMOVAL  
**Burial**

23b. DATE  
**12/16/86**

23c. NAME OF CEMETERY OR CREMATORY  
**Cedar Hill Cemetery**

23d. LOCATION  
 CITY OR TOWN COUNTY STATE  
**Suitland P.G. Maryland**

24. FUNERAL DIRECTOR  
 NAME ADDRESS  
**George P. Kalas Funeral Home Oxon Hill, Md.**

25a. DATE REC'D. BY REGISTRAR  
**DEC 16 1986**

25b. REGISTRAR'S SIGNATURE  
**Julia Davidson-Randall**

26. TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 BP  
 25M

DHMH - 17  
 (VR A15 ME (5))

0273 101703

John W. ... T.O.A.

John W. ... T.O.A. ...

COLLECTION



John W. ... T.O.A. ...

026616 DEC 10 86

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 33000	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME <b>LEON S. TURNER</b>										2a. DATE OF DEATH MONTH <b>12</b> DAY <b>3</b> YEAR <b>86</b>	
3. SEX <b>MALE</b>										2b. HOUR <b>11:33</b> P.M.	
4. RACE <b>CAUCASIAN</b>										5. DATE OF BIRTH MONTH <b>9</b> DAY <b>1</b> YEAR <b>28</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>										6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MECHANIC</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>ELEVATOR</b>											
13a. STATE <b>MARYLAND</b>										13b. COUNTY <b>A.A.</b>	
13c. CITY OR TOWN <b>SEVERN</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>RAYMOND</b> MIDDLE <b>L.</b> LAST <b>TURNER</b>										15. MOTHER'S MAIDEN NAME FIRST <b>NELLIE</b> MIDDLE <b>BARR</b> LAST <b>BARR</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>										16b. SOCIAL SECURITY NO. <b>WW 11 216 22 8068</b>	
17. INFORMANT <b>Severn, Maryland 21144</b> <b>IVALENE TURNER 1522 Florida Avenue</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia see.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bleeding see. Lung ca</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 months</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/1/74</b> 19____ to <b>12/1/86</b> 19____, that (I) (we) lost saw the deceased alive on <b>12/1/86</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Silvino B. Muneses M.D.</b> DEGREE								22c. DATE SIGNED <b>12/4/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Silvino B. Muneses M.D.</b>								22e. ADDRESS <b>3721 Potee Street Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>12/8/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Raymond E. Fink Glen Burnie, Md. 21061</b>								25a. DATE REC'D. BY REGISTRAR <b>DEC 8 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Pudock</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

1 2 3 4

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33607  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WINFIELD NMN TURNER</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>5</b> YEAR <b>86</b>		2b. HOUR <b>1131AM</b>	
3. SEX <b>MALE</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>26</b> YEAR <b>1897</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A.A. GENERAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WORKMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>md</b> COUNTY <b>W.A. CO</b> CITY OR TOWN <b>ANNAPOLIS</b>			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>HENRY</b> LAST <b>TURNER</b>			15. MOTHER'S MAIDEN NAME FIRST <b>SARAH</b> MIDDLE <b>GRIFFIN</b> LAST <b>GRIFFIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-12-2738A</b>		17. INFORMANT ADDRESS <b>RACHEL BURGESS TURNER 7312 Edgewood Rd</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
**Hypertension, Left hemiparesis and aphasia**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 19</b> , 19 <b>83</b> , to <b>Dec 5</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>Nov 14</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.			
22b. SIGNATURE <b>Charles W. Kinzer</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>5 Dec '86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES W. KINZER MD</b>		22e. ADDRESS <b>ANNAPOLIS, MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>Dec 11-1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ANNAPOLIS Neck</b>	23d. LOCATION CITY OR TOWN <b>ANNAPOLIS</b> COUNTY <b>A.A.</b> STATE <b>MD</b>
24. FUNERAL DIRECTOR NAME <b>C.E. Hicks III</b> ADDRESS <b>1922 Forest Drive</b>		25. DATE REC'D. BY REGISTRAR <b>DEC 8 1986</b>	26. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please return it to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page and attach it to the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

026002 DEC 1

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 33608

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) George N. Tyler Jr.			2a. DATE OF DEATH MONTH DAY YEAR Dec 1, 1986			2b. HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept 18, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Boat Builder	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George N. Tyler		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Milton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-07-8088	
17 INFORMANT George N. Tyler, III		18 ADDRESS Same as #13		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>AS CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min. <u>11</u> year <u>1</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> 19 <u>86</u> to <u>12/1</u> 19 <u>86</u> , that (I) (we) lost above, (I) (we) did not see the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE <u>William C. Weintraub</u> MD		22c. DATE SIGNED 12/2/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) William C. Weintraub		22e. ADDRESS 2568 A Riva Rd. Annapolis, MD.	
23a. BURIAL, CREMATION, REMOVAL (TYPE IF)		23b. DATE Dec 4, 1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD	
24 FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis MD		25a. DATE REC'D. BY REGISTRAR DEC 3 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Radabaugh</u>			

BP

Memorandum

TO : Mr. [illegible]

FROM : Mr. [illegible]

SUBJECT : [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

1

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 0 0 9

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (Last, first, middle) <b>John Joseph Vanyo</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec 22 1986</b>		2b. HOUR <b>P. M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 13, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>710 Americana Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b>			13c. COUNTY <b>AA</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Vanyo</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Peterlik</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>053-03-2668</b>		17. INFORMANT ADDRESS <b>same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>parkinson's disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>approx. 1984</b> , to <b>present</b> , 19____, that (I) (we) last saw the deceased alive on <b>approx 12-7</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jacob E. Tectorbaum MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/23/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jacob E. Tectorbaum</b>		22e. ADDRESS <b>139 Old Solomon Isl Rd 21401</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Dec 27 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakemont</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Davidsonville AA MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Taylor Funeral Chapel-Annapolis, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 23 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Dinkin-Radach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove Burialpapers Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. The medical examiner must be notified of a death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified of a death.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 6 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Kenneth Earl Vogt, Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 1, 1986			2b. HOUR 10:45 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 29, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 200 Oakleigh Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder	
12b. KIND OF BUSINESS OR Finish Metal							
13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 200 Oakleigh Avenue 21061							
14. FATHER'S NAME FIRST MIDDLE LAST Bernise Vogt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Pfeiffer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT (Wife) Mrs. Mary B. Vogt		ADDRESS Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Progressive hepatic metastases</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> , 19 <u>86</u> , to <u>11/17</u> , 19 <u>86</u> , that (I) (we) lost <u>saw the deceased alive on Nov 17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Karen M. Lichtenfeld</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Karen M. Lichtenfeld		22e. ADDRESS 101 W. Reed Street Suite 515 Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 1 1986		25b. REGISTRAR'S SIGNATURE <u>Lia Dorian-Randall</u>			

BP

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BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove earlier papers and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item: 12a G-622 12/23/86

FOR  
STATE F.H. cm  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 0 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALLEN B VOSS			2a. DATE OF DEATH MONTH DAY YEAR Dec. 6, 1986			2b. HOUR M			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Civil Service	
13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1000 Cedar Ridge Ct, 21403	
14. FATHER'S NAME FIRST MIDDLE LAST Julius A. Voss		15. MOTHER'S MARDEN NAME FIRST MIDDLE Marie Mattson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO) (IF YES, IN WHICH SERVICE) YES WWII		16b. SOCIAL SECURITY NO. 025-05-1977		17. INFORMANT FLORENCE A. VOSS #13 ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure, Hypotonia DUE TO, OR AS A CONSEQUENCE OF (b) <del>Renal Failure</del> , OLD MI Ischemic Cardioropathy DUE TO, OR AS A CONSEQUENCE OF (c) <del>Old MI</del> ASCVD PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) CA of Calvin								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1977, to 1986, that (I) (we) lost saw the deceased alive on 12/5/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Brien				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/6	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brien				22e. ADDRESS 51 Franklin St, ANNAPOLIS, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/86		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pawleys, Essex, MA.			
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel ANNAPOLIS, MD				25a. DATE REC'D. BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

John D. 1000

Handwritten notes and signatures, including a signature that appears to be "John D." and some illegible text.

4

029457 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and deposit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 3 3 6 1 2			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret Thackray Weems</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Dec. 26, 1986</b>		2b. HOUR <b>8 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 17, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>95</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Severna Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Center</b>		12a. USUAL OCCUPATION (1) PR. OF WORK FOR MOST OF WORKING LIFE <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George E. Thackray</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Shaghnessy</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>545-14-9135</b>	
17. INFORMANT <b>Margaret Weems Dodds</b>		ADDRESS <b>1837 Pleasant Plains Rd. Annapolis</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>STROKE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b> <b>1 yr</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-21</b> , 19 <b>85</b> , to <b>12-26-86</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>12-10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John Jackson</b> MD				22c. DATE SIGNED <b>12-26-86</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN JACKSON</b> MD	
22e. ADDRESS <b>1833 FOREST DR. ANNAPOLIS, MD 21401</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/26/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. MD</b>	
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel-Annapolis, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John Jackson</b>	

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DHMH - 16 60M 7/84  
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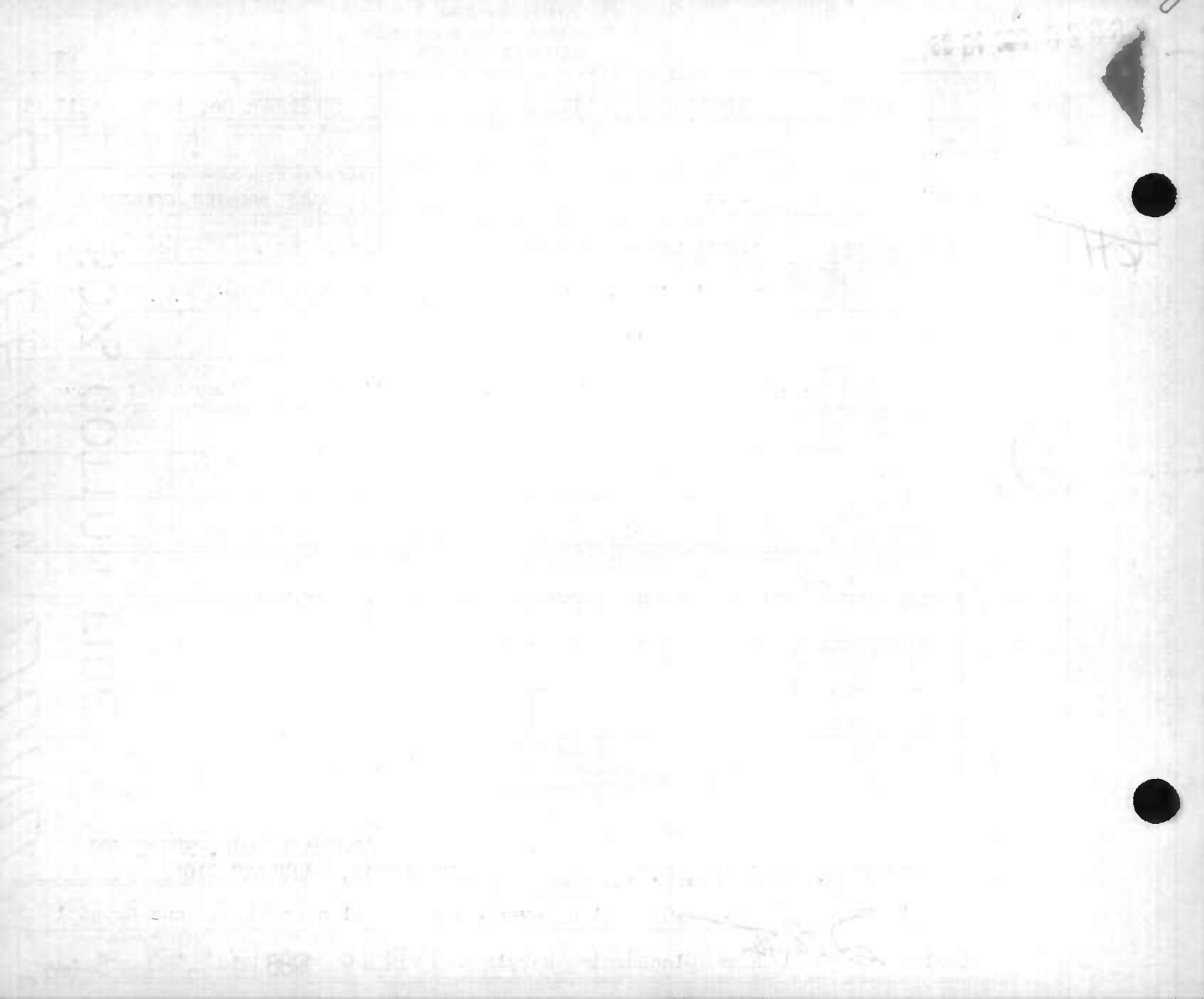
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT) <b>HOMER EDWARD WELLER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 06, 1986</b>		2b. HOUR <b>1215 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 25 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Track Sup.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Chessie System</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Page Weller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosemond Eichleberg</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR OR DATES) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>W.W.11 705.14.0049</b>		17. INFORMANT (Wife) <b>Mrs. Edna Weller</b>		ADDRESS <b>Same AS 13 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF <b>Lung</b> (b) <b>CHRONIC Lung Disor</b> DUE TO, OR AS A CONSEQUENCE OF <b>Ischemic Heart Failure</b> (c) <b>Ischemic Heart Failure</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>As chronic</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-4</b> , 19 <b>86</b> , to <b>12-6</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>12-6</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>med B/Kern</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/6/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. KROOPNICK, M.D.</b>				22e. ADDRESS <b>95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 10, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Anne Arundel MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Singleton Funeral Home Glen Burnie Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	



027150 DEC 15-86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 3 6 1 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Florence V Wilde</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>8</b> YEAR <b>86</b> 2b. HOUR <b>1815</b> M		
3. SEX <b>F</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>June</b> DAY <b>25</b> YEAR <b>1912</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Shady Side, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co. MD.</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>household</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Shady Side</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1362 Wilde Rd. 20764</b>	
14. FATHER'S NAME FIRST <b>Andrew</b> MIDDLE LAST <b>Phipps</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Betty</b> MIDDLE LAST <b>Lee</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212 46 8712</b>		17. INFORMANT ADDRESS <b>Mrs Peggy Tucker same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Breast cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>14 mos.</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 85</b> , to <b>Dec 8 86</b> , that (I) (we) last saw the deceased alive on <b>Dec 8 86</b> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stuart E. Selowick, M.D.</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/8/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stuart E. Selowick, M.D.</b>				22e. ADDRESS <b>51 Franklin St. Annapolis, Md. 21404</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/10/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodfield CEM</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>GALESVILLE A.A. MD.</b>					
24. FUNERAL DIRECTOR NAME <b>HARDESTY FUNERAL HOME</b>		25. RIDGELY AVE. ADDRESS <b>ANN. MD. 21401</b>		26a. DATE REC'D. BY REGISTRAR <b>DEC 12 1986</b>	
26b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Bandall</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the attendant papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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50% COTTON FIBER

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100% COTTON FIBER

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FOR  
STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33615

1. DECEASED NAME (TYPE OR PRINT) <b>Bernard Williams</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 <b>11 27 86</b>			2b. HOUR M <b>1127</b>		
3. SEX <b>M</b>	4. RACE <b>Neg</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 29 26</b>	6. AGE (IN YEARS) (LAST DAY) <b>60</b> YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 27 86</b>	2d. HOUR M <b>1127</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md</b>		13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>868 Spa. Rd. 21401</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Williams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Wells</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>April 25 1945 - 10/7/46</b>		17. INFORMANT (Wife) ADDRESS <b>Barbara Williams 5403 5th St. N.W. Wash. D.C.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>William P. Jones</b>				TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>				ADDRESS <b>695 America Ct. Davidsville, Md. 21035</b>				

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12-3-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham Vet. Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham P.G. M.D.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Comer-Hodges 4901 Marlboro PK. Coral Hills Md.</b>		25. DATE REC'D. BY REGISTRAR <b>DEC 15 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

11 50 26

11 50 26

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11 50 26

11 50 26

11 50 26

028076 DEC 19

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH			MONTH			DAY			YEAR			2b. HOUR								
MICHAEL BRIAN WOODCOCK												12-19-86												M								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR.			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD			MONTH			DAY			YEAR			2d. HOUR		
Male			White			7 MONTH 18 DAY 61 YEAR			25 YRS.			MONTHS			DAYS			HOURS			MIN			12-19-86			5am			M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																							
MD			USA						Anne Arundel County																							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																							
Glen Burnie			North Arundel Hospital			Machinist																										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS																				
MD			Howard			Elkridge			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			6985 Dorsey Road 21227																				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																													
FIRST			MIDDLE			LAST			FIRST			MIDDLE			LAST																	
Gary			W.			Woodcock			Judith			A.			Dohler																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																							
NO			218-88-8065			Judith A. Sturgeon			Same as #13e																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I DEATH WAS CAUSED BY:																																
IMMEDIATE CAUSE (a) <u>8150</u> HEAD AND NECK INJURIES																																
DUE TO, OR AS A CONSEQUENCE OF																																
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																																
(b) _____																																
DUE TO, OR AS A CONSEQUENCE OF																																
(c) _____																																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																										
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																										
			4:00AM 12-19-86			driver of an auto/fixed object collision																										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE																	
			street			Dorsey Rd. & Parkway Dr.			Glen Burnie, Md.																							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																													
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED																										
Margarita A. Korell, M.D.			M.D. Assistant			MEDICAL EXAMINER			12-19-86																							
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY			STATE																	
Cremation			12-19-86			Security Process			Baltimore,																							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																							
Cremation Society of MD, Baltimore, MD			299 Frederick Road			DEC 21 1986																										
			21228																													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL BETWEEN 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS,  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/B4  
25MBP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))



026230 DEC - 51

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 33517	
1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Martha</u> MIDDLE: <u>Elizabeth</u> LAST: <u>Wright</u>						2a. DATE KNOWN OF DEATH MONTH: <u>12</u> DAY: <u>01</u> YEAR: <u>1986</u>		2b. HOUR M: <u>1601</u>			
3. SEX <u>F</u>	4. RACE <u>Neg</u>	5. DATE OF BIRTH MONTH: <u>12</u> DAY: <u>07</u> YEAR: <u>20</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>65</u> YRS.	IF UNDER 1 YR. MONTHS: _____ DAYS: _____	IF UNDER 24 HRS. HOURS: _____ MIN: _____	2c. DATE PRONOUNCED DEAD MONTH: <u>12</u> DAY: <u>01</u> YEAR: <u>1986</u>		2d. HOUR M: <u>1601</u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>AA</u>					
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>ANNE ARUNDEL CO. HOUSEWIFE</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Md.</u>		13b. COUNTY <u>AA</u>		13c. CITY OR TOWN <u>Annapolis</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>1610 D. Berry Ct. #1401</u>					
14. FATHER'S NAME FIRST: <u>Clarence</u> MIDDLE: <u>Washington</u> LAST: <u>Williams</u>				15. MOTHER'S MAIDEN NAME FIRST: <u>Margaretta</u> MIDDLE: <u>Williams</u> LAST: <u>Williams</u>				ADDRESS <u>Annapolis, Md. 21401</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Atha Hoskins-1830 Clay St.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Cardiac Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <u>C.O.P.D.</u> (b): _____ DUE TO, OR AS A CONSEQUENCE OF (c): _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION _____				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>William P. Jones, MD</u>				TITLE (SPECIFY) M.D. <u>Deputy</u> MEDICAL EXAMINER		DATE SIGNED <u>12-01-86</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>William P. Jones, M.D.</u>				ADDRESS <u>695 America Crt. Davidsonville, Md. 21035</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/4/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn Mem. R.</u>		23d. LOCATION CITY OR TOWN: <u>Annapolis</u> COUNTY: <u>AA</u> STATE: <u>Md.</u>					
24. FUNERAL DIRECTOR <u>William Keeseys Sons</u>				ADDRESS <u>Montgomery, Pa. 501 West St.</u>		25a. DATE REC'D. BY REGISTRAR <u>12-1-86</u>		25b. REGISTRAR'S SIGNATURE _____			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.				EST					
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P M	
ANNIE LUCINDA WYATT								DECEMBER 11, 1986		3:30 P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		April 22, 1905		81 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL				Ret. Seamstress					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		AA		Hanover				7398 Camelot Court		21076	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Robert Weidner				Leona Trent							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		228-20-4506		Mrs. Porter, Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/27/86</u> to <u>12/11/86</u> , that (I) (we) last saw the deceased alive on <u>12/11/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Cyriac</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/12/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKUMKAL V. CYRIAC, M.D.				22e. ADDRESS 14 WELLHAM AVENUE GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Dec. 29, 86		Woodlawn Mem. Gardens		Norfolk Virginia					
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				ADDRESS 21061				25a. DATE REC'D. BY REGISTRAR DEC 16 1986		25b. REGISTRAR'S SIGNATURE	

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